Issues Relating to Veterans Affairs

May 1998

Human Resources or Economic Security Matters Evaluation Committee

Indiana Legislative Services Agency

Legislative Evaluation and Oversight

The Office of Fiscal and Management Analysis is a Division within the Legislative Services Agency that performs fiscal, budgetary and management analysis. Within this office teams of program analysts evaluate state agency programs and activities as set forth in IC 2-5-21.

The goal of Legislative Evaluation and Oversight is to improve the legislative decision-making process and, ultimately, state government operations by providing information about the performance of state agencies and programs through evaluation.

The evaluation teams prepare reports for the Legislative Council in accordance with IC 2-5-21-9. The published reports describe state programs, analyze management problems, evaluate outcomes, and include other items as directed by the Legislative Evaluation and Oversight Policy Subcommittee of the Legislative Council. The report is used by an evaluation committee to determine the need for legislative action.

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Preface

Each year, the Legislative Services Agency prepares reports for the Legislative Council in accordance with IC 2-5-21. In accordance with Legislative Council Resolution 15-96, this report concerns issues relating to Veterans Affairs. It has been prepared for use by the Human Resources or Economic Security Matters Evaluation Committee.

We gratefully acknowledge all those who assisted in the preparation of this report. The staffs of the Department of Veterans Affairs and Veterans' Home were helpful in their response to our requests for information.

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Executive Summary of the Evaluation of Veterans Issues

Indiana Veterans Home and Advisory Committee.

Located in West Lafayette, the Indiana Veterans Home was established in 1896 to care for disabled or destitute veterans. Honorably discharged veterans and nurses with service-connected disabilities who have served during any of the U.S.'s authorized military campaigns and their spouses are eligible for admission.

The Home is the fourth largest long-term care facility in Indiana and is administered by the State Department of Health. The Home consists of 27 buildings on 250 acres overlooking the Wabash River. Residents are classified as self-care, assisted living, or comprehensive nursing care, depending upon medical needs and ability to care for themselves. The Home currently has 455 licensed beds with significant unused capacity.

Funding. Funding for the Home comes from residents (17.4%), federal VA per diem payments (28.8%), and state appropriations (53.8%). The Home had State General Fund appropriations of $8.84 million in FY98 and $8.86 million in FY99.

State Department of Health Survey. The State Department of Health periodically conducts surveys at licensed health care facilities to determine compliance with state health regulations. The Home's 1997 survey indicated that the Home was free of any care-related deficiencies and had only three non-care deficiencies. This represents a significant improvement over the 1994 survey when the Home was cited for approximately 100 deficiencies.

Staffing Issues. The major staffing issues confronting the Home were staffing shortages among its nurse aides and licensed practical nurses (LPNs). The Home has experienced a high turnover rate among nurse aides for the past several years. Adding to the retention problem is the inability to recruit sufficient applicants to fill existing nurse aide and LPN vacancies. Low wages, shift schedules, low unemployment rates in the community, absenteeism, and general working conditions contribute to staffing shortages. Staffing shortages not only affect patient care but also result in increased expenditures for overtime and employment agency staff, increased training costs, a forced reduction in resident census. Proposals include (1) salary increases; (2) shift differentials; (3) four-day work weeks; (4) providing a menu of fringe benefits from which to choose; (5) paying for unused sick leave; (6) operating as a clinical training site; (7) improving orientation and training; (8) providing light-duty job assignments; (9) providing a lift-free environment; and (10) reestablishing a float pool of part-time and intermittent staff.

Home's Participation in Medicaid Program. If the Home participated in the Medicaid Program, an estimated $1.5 million to $2.9 million in federal revenues would be generated annually. The principal eligibility requirements that affect program recipients, aside from level of care, are the income and resources of each individual. A perceived major disadvantage of participation in the Medicaid Program is that the resident and spouse, if one exists, would be required to be impoverished much beyond his or her current levels in order to gain eligibility. However, federal Medicaid or VA requirements do not mandate levels of impoverishment much more severe than what the residents are currently subject to at the Home.

Although Medicaid participation could result in some additional administrative costs, participation could also mean potentially significant amounts of additional federal revenue with minimal impact on the welfare of the residents. In fact, residents could be made no worse off, and perhaps better off, by increased investment in capital facilities, programming, and other improvements affecting the general quality of life of the veterans. Improvements could be financed from a portion of the new Medicaid revenues. Closer examination of the potential costs and benefits from participation in the Medicaid Program appear to be warranted.

Other Issues Facing the Home. *Procurement Procedures.* The Home has identified areas where expenditures might be reduced. One area is the Quantity Purchase Award (QPA). QPAs are contracts granted by the State Department of Administration to the lowest price vendor capable of supplying the necessary goods and services to operate state facilities. Potential advantages from operating outside the QPA for supplies needed for the Home (e.g., nursing, housekeeping, office supplies, automation and communications equipment, as well as commodities such as natural gas) include (1) ordering efficiencies; (2) inventory control; (3) production management; (4) administrative streamlining; and (5)

cost management.

Indiana Residency Requirement. The current statutory admissions policy for the Home requires a five-year residency in Indiana immediately preceding application to the Home. A review of the residency requirements in 44 other states with veterans homes revealed that Indiana has one of the most restrictive residency requirements.

Indiana Department of Veterans Affairs and Advisory Commission

The Indiana Department of Veterans Affairs (IDVA) was established in 1945 and given "full authority to aid and assist veterans of the armed forces of the United States entitled to benefits or advantages provided on or after March 3, 1945, by the United States, the state of Indiana, or any other state or government." (IC 10-5-1-1) The IDVA consists of nine employees and houses the State Approving Agency (SAA). The IDVA is also responsible for the construction and operation of the Indiana Veterans Memorial Cemetery located in Madison.

In addition to state officers, 91 county service officers help veterans apply for federal, state, and local benefits. Benefits include burial allowances, burial in a state veterans cemetery, recording of discharge papers, remission of fees at a state-assisted college or university for the children of disabled veterans, veterans preference for state employment, property tax deductions, and admission to the Indiana Soldiers and Sailors Children's Home for relatives of veterans. IDVA certifies a veteran's eligibility for many of these programs and assists veterans in securing federal benefits.

Appropriations to the IDVA were $472,793 for FY98 and $573,424 for FY99. In addition to these appropriations and as part of the IDVA's budget, IDVA controls a $10,000 annual appropriation for the Combat Veterans Consortium.

The four-member Veterans' Affairs Commission supervises and controls the IDVA. The Commission meets quarterly to promulgate rules and regulations for the administration of veterans' affairs statutes; advise the veterans' State Service Officer on issues pertaining to the welfare of veterans; and determine the general administrative policies within the IDVA.

Personnel Issues. *Non-Merit to Merit Conversion.* The IDVA is a merit agency, subject to the State Personnel Act. When an agency's employees are non-merit, or not part of a union settlement, and do not have a unique statutory provision conferring due process rights under common law, they are considered "at will" employees. "At will" employment means that seven IDVA employees can be terminated at any time, for any reason, with or without cause. Conversion to merit status could provide more security, stability, and "institutional memory." Negative consequences of such a change could include more bureaucratic hiring and separation procedures and less flexibility for the director.

Reclassification of SAA Employees. The IDVA reported a 75% turnover rate within the SAA unit in the last six months and attributes the inability to retain SAA employees to low salaries. In a survey of the four states bordering Indiana, Indiana does have the lowest salaries for its SAA employees. SAA employee salaries, travel, and administrative expenses are 100% federally funded. By reclassifying SAA employees, Indiana could take advantage of additional federal dollars.

County Service Officers. County Services Officers (CSOs) assist the IDVA in obtaining federal- and state-funded benefits for eligible veterans. By state statute, the county executive of each county is required to designate a CSO. Because CSOs are employed by counties, in most cases, the IDVA lacks effective authority over the CSOs since CSOs are not held accountable to the IDVA.

Indiana ranks 48th in the country in benefits per veteran. There is also much variation among the counties in Indiana. Benefits ranged from $354 per veteran in Porter County to $1,188 in Switzerland County. Possible alternatives include increased training for CSOs or increasing the accountability and authority IDVA has over the CSOs.

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Indiana State Veterans' Home

Overview of the Indiana Veterans' Home

History of the Veterans' Home. Located in West Lafayette, the Indiana Veterans' Home (Home) was established in February 1896 as the "Indiana State Soldiers' Home" to care for disabled or destitute honorably discharged veterans who have resided in Indiana for at least five years and who have wartime service. (The home was renamed the Indiana Veterans' Home in 1976.) Honorably discharged veterans and nurses who have service-connected disabilities and who have served during any of the United States' authorized military campaigns are eligible for admission. In addition, the spouses and surviving spouses of eligible veterans may be admitted.

In 1923, the General Assembly authorized counties to appropriate local money for building cottages at the site near Lafayette to care for disabled and destitute veterans. In 1957, a legislative commission, created to study the Veterans' Home facilities, found that 75% of the 95 frame cottages were too old, unsafe, or expensive to maintain. The Commission recommended a long-term building project to be funded by federal funds and a portion of the Veterans' Home Comfort and Welfare Fund into which resident fees are deposited.

The building program, which began in the early 1960's, resulted in an 800-bed facility by 1986. However, as of March 1998, only 455 beds were licensed by the State Department of Health.

As of October 1997, the Home was the fourth largest long-term care facility in the state. Residents include disabled, ill, or destitute Indiana veterans, their spouses, or widowed spouses who required residential or comprehensive nursing care. The majority of the residents are male and elderly. Residents at the Home represent five war periods as detailed in Exhibit 1.

The Veterans' Home is under the jurisdiction of the Indiana Department of Health. The Superintendent of the Home is accountable to the State Health Commissioner. As of April 1998, the Home had a staffing cap of 474 full-time employees (FTEs). There were 467 full-time positions and 21 part-time positions available, for a total of 488 positions. The Home employed 439 individuals and had 49 vacancies. All but one vacancy were full-time positions, and 31 of the vacancies were in the area of nursing services.

Exhibit 1. Indiana Veterans' Home Census by War Period.

War Period	Vets	Spouses	Widows	Total
WWI	0	0	2	2
WWII	225	5	34	264
Korean	58	1	1	60
Viet Nam	34	0	0	34
Gulf War	1	0	0	1
Total	**318**	**6**	**37**	**361**

The Veterans' Home also employs contract employees. As of April 1998, the Home had five full-time and 13 part-time contract positions with no vacancies. In addition to the regular contract positions, a nurse agency provides nurses and nurse's aides to cover shifts as needed.

The Home consists of 27 buildings and numerous monuments on 250 acres overlooking the Wabash River. Three buildings, Ernie Pyle Hall, Mitchell Hall, and MacArthur Hall, house the Home's comprehensive care facilities. The Tecumseh and DeHart buildings house assisted living residents. Self-care residents reside in Lincoln Hall.

Residents of the Indiana Veterans' Home are classified into one of three groups--self-care, assisted living, and comprehensive nursing -- depending on their medical needs and ability to care for themselves. As of March 1998, the Veterans' Home census showed 273 residents in comprehensive nursing beds, 49 assisted living residents, and 39 self-care residents

for a total census of 361. The Home provides total care for residents. Medical care is provided through several sources including staff doctors, nurses, therapists, dentists, and pharmacists as well as the U.S. Veterans' Administration Hospital system and local private providers (area doctors, hospitals, and clinics).

The Indiana Veterans' Home provides on-site many ancillary services such as hair care, postal services, and laundry. Residents who are physically able may leave and return to the Home at any time. Residents may also have visitors at anytime.

Many of the major veterans' organizations provide support to the residents by sponsoring activities such as parades, picnics, bingo, parties, and trips. These organizations also donate equipment to the Home.

Indiana Veterans' Home Budget

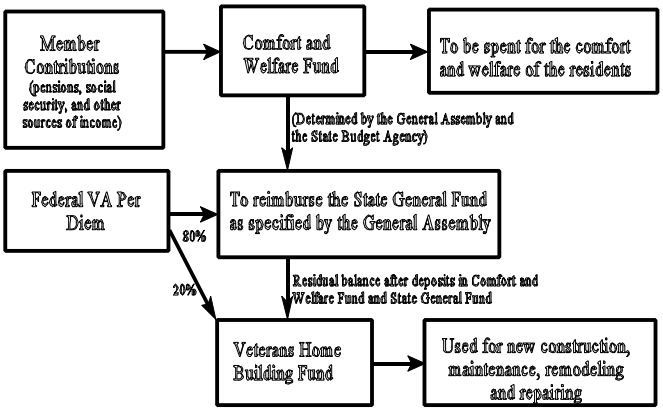
Funding for the Home. Funding for the Indiana Veterans' Home comes from three primary sources: federal VA per diem payments (28.8%), resident contributions (17.4%), and State General Fund appropriations (53.8%). Based on the FY97 average daily cost, residents contribute $23.56 per day, VA per diem averages $39.00, and State General Fund contribution averages about $73.00 per day.

Federal Reimbursement. The Home receives a federal VA per diem in the amount of $17.78 per day for veterans residing in self-care and $40.00 for those receiving assisted living or comprehensive nursing care. Eighty percent of the federal per diem is deposited in the State General Fund as reimbursement to the state for the Home's operating costs, and 20% is deposited in the *Veterans' Home Building Fund* for the Home's capital budget (IC 10-6-1-20).

Resident Contributions. Residents typically receive income from one or more of the following sources: Social Security, VA pensions, other pension plans, and money from estates. Residents are permitted to keep $130 per month for personal needs and then must pay the Home as much of the daily rate as their income allows.[1] The daily rate is based on the per capita costs for the preceding fiscal year. The Superintendent of the Home collects the residents' payments and deposits them in the *Comfort and Welfare Fund* (IC 10-6-1-9).

Contributions from the State General Fund. For each biennium, the General Assembly appropriates to the Veterans' Home an amount sufficient to cover some portion of operating costs.

The following schematic shows how revenues collected from residents and from the federal VA are dispersed.



Veterans' Home Operating Budget. Exhibit 2 shows the history of appropriations from the State General Fund and from the Comfort and Welfare Fund since 1980 for operating expenses. The percentage of contributions from the State General Fund and Federal Reimbursements has declined since 1980 from 82% of total appropriations to 54% in FY99. This decline demonstrates a greater reliance on support from the residents.

Veterans' Home Capital Budget. Appropriations for the capital budget for the past 20 years have come from the Veterans' Home Building Fund. As Exhibit 3 indicates, appropriations for preventive maintenance and for repairs and

[1] A lien is placed against assets above $8,499; however, it is not exercised against a spouse or dependent child living in the veteran's private residence when the veteran dies.

rehabilitation have been consistently in the range of $2 million per year over the past four years. For the 1997-99 biennium, an additional $4.9 million was appropriated for an Alzheimer unit.

Expenditures of the Indiana Veterans' Home

Expenditures from the Comfort and Welfare Fund.

Monies in the Comfort and Welfare Fund are used (1) for the comfort and welfare of the residents, (2) for reimbursing the State General Fund in an amount specified by the General Assembly, and (3) for the Veterans' Home Building Fund (IC 10-6-1-9). If revenues in the Fund exceed expenses, the remainder is deposited in the Veterans' Home Building Fund (IC 10-6-1-20), which is used to reimburse the State General Fund.

Veterans' Home Expenditure History.

FY93 and FY94 reversions to the State General Fund totaled more than $3 million (Exhibit 4). FY95 and FY96 reversions totaled $970,000. During FY97, the Veterans' Home reverted $3,749 and needed an additional appropriation of $764,000 to the $18.1 million originally appropriated. Transfers were needed to fund natural gas fuel costs that were higher than projected and increases in the costs of using a contract nurse agency.

Future Pressures on Expenditures.

The following expenditures could increase significantly in the future:

Health Care Provider Contract Services. The contract with the agency that provides nursing staff increased by approximately $500,000 since 1995; actual costs were $600,000 in FY97; and costs are projected to be $400,000 in FY98. While these costs appear to be decreasing, expenses could significantly increase in the future, especially if the nurse and nurse aide staffing problems

Exhibit 2: *Over the past 20 years, state support for the IVH operating budget has come increasingly from the Comfort and Welfare Fund and Federal Reimbursement.*

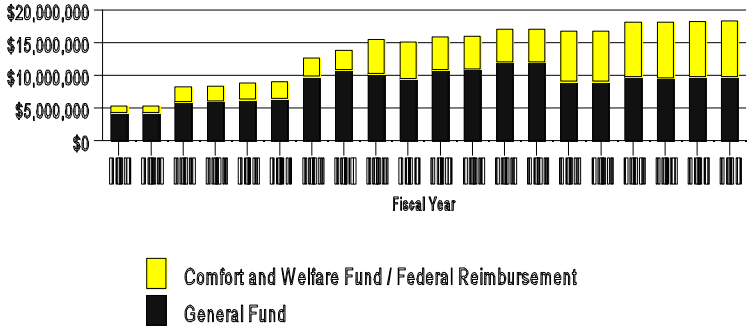


Exhibit 3: *Appropriations for the capital budget comes from the Veterans Home Building Fund. This fund is comprised of payments from the benefits received by the residents.*

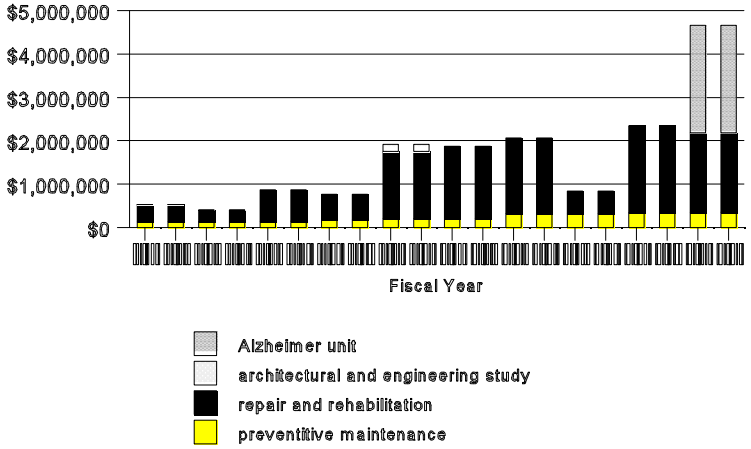
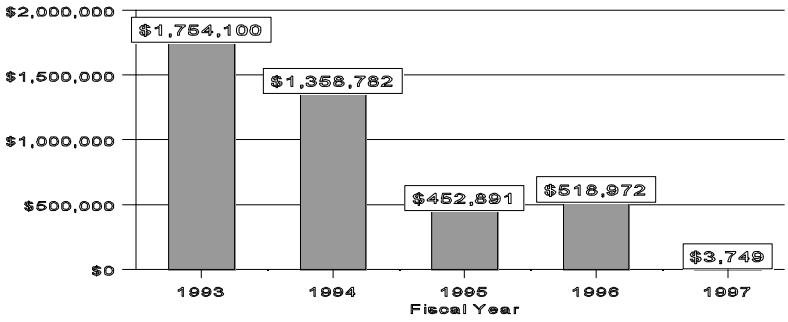


Exhibit 4: *The amount reverted to the State General Fund has declined significantly over the past five years.*



discussed later in the report are not resolved.

Fuel Costs. Fuel costs increased by $250,000 in FY97; however, because of the relatively mild winter in 1998, the Home will be within budget for fuel costs. However, the Superintendent anticipates a 10% increase annually in future years.

Personnel Costs. Overtime cost approximately $1.1 million in FY98. Salaries and wages will increase 4-8% per employee each year based on the salary adjustment granted to all state employees. Salaries and wages totaled about $8.7 million for FY98. Applying an average 6% increase per year would result in an additional $522,000 expense per year for personnel.

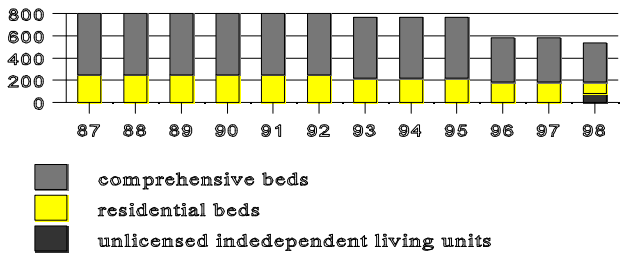
Vehicle and Equipment Repairs. Vehicle and equipment repairs are expected to increase by approximately 20% annually resulting in a $2,000 per year increase in expenditures. Aging vehicle and equipment inventory add to the repair costs.

Food, Medical, and Housekeeping Supplies. The Home anticipates an increase in food, medical, and housekeeping supplies of approximately 10% annually. Increases for food totaled about $50,000 during FY98. Medications use was up approximately 80%. The average cost of medication per resident went from about $62 in January 1996 to $111 in January 1997. The cost of medication has increased as well as the usage. Costs for oxygen increased to approximately $80,000 in FY98. Worker's compensation medical benefits are projected to be approximately $280,000 in FY98.

Number of Beds and Trends in Usage.

Exhibit 5 shows the change in the number of licensed and unlicensed beds at the State Veterans' Home since 1987. The number of beds licensed by the state has declined from 800 in 1985 to 455 in 1998. As part of this reduction in licensed beds, 80 beds were reclassified as unlicensed beds in February 1998. Currently, 39 self-care residents occupy these units.[2]

Exhibit 5: *The number of beds licensed by the State Department of Health has declined 43% from 800 in 1987 to 455 in 1998.*



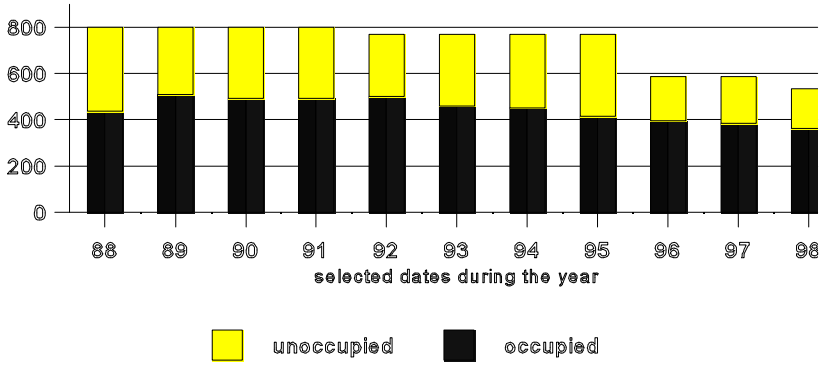
The number of residents in the Veterans' Home has declined as well. Exhibit 6 indicates the number of beds at the Home that were occupied as compared to those that were empty for the eleven-year period between 1988 and 1998. This exhibit also compares the number of unoccupied to occupied beds for the ten largest long-term care facilities based on the most recent census reported by the State Department of Health (State Department of Health, 1997). This exhibit also shows the percentage of occupied and unoccupied beds statewide in both 1994 and 1996.

Several factors appear to contribute to the decline in the number of residents at the Veterans' Home:

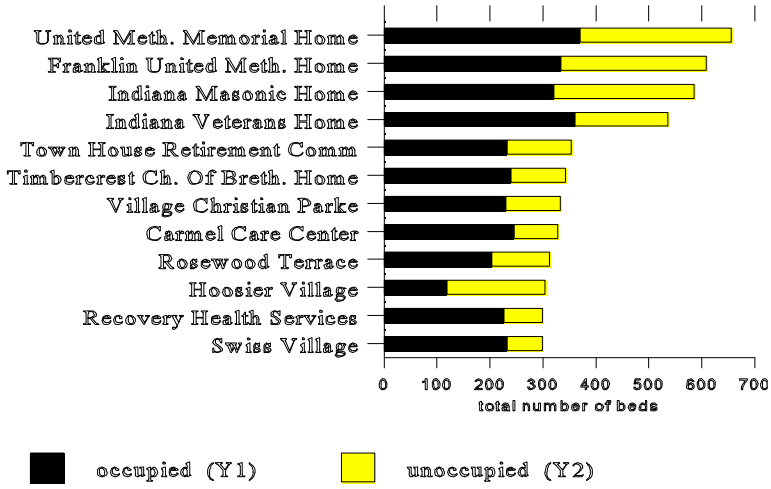
- The Home is not able to retain the necessary number of nurse aides to keep the number of beds licensed at the higher levels.
- Older adults are living longer in their own homes.
- There is an increasing number of home health services, adult day care, and other community-based services that are keeping people in their homes.

[2]The Superintendent indicated that to reduce costs associated with state licensing and membership fees to the Indiana Association of Homes and Services for the Aging, he requested the State Department of Health to reclassify these as unlicensed beds. The State Department of Health charges $100 for the first 50 beds and $2.50 for each additional bed annually as a licensing fee. The Indiana Association of Homes and Services for the Aging charges $10.66 per bed for annual membership. Beds occupied by assisted living and self-care residents are not required by state or federal law to be licensed. However, the Home and the State Department of Health have chosen to have only self-care residents occupy unlicensed beds.

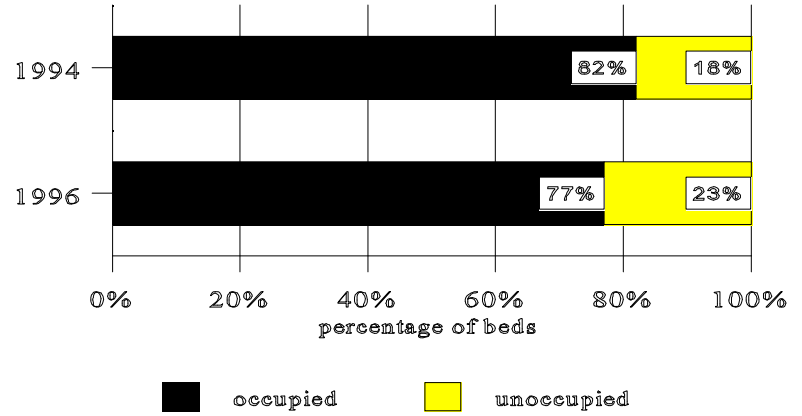
Exhibit 6: *Trends in Usage. Between FY 1989 and 1998, both the capacity and the number of occupied beds has declined at the IVH…*



…reflecting a similar trend in occupied beds among the twelve largest long-term care facilities in Indiana (1997)…



… and reflecting a decline in the statewide percentage of occupied beds between 1994 and 1996 as reported by the Department of Health.



- The number of nursing home beds available statewide is increasing. This increase allows some adults to choose to stay closer to their homes, families, and community rather than move to the Veterans' Home.

The federal Department of Veterans' Affairs (VA) operates a series of hospitals and health-care facilities statewide that may be a source of competition to the State Veterans' Home, although VA hospitals serve a slightly different population. VA hospitals tend to focus on extended care services (services of limited duration for individuals rehabilitating after a hospital stay) rather than long-term care services.

VA hospitals are located in Fort Wayne, Marion, and Indianapolis. The VA also operates nursing homes in Fort Wayne (52 beds), Indianapolis (15 beds), and Marion (240 beds) for a total of 307 beds statewide. The 240-bed nursing home in Marion was opened in July 1997 and is considered to be a state-of-the-art facility for geriatric adults who have a psychiatric diagnosis. The VA also has outpatient satellite clinics in Crown Point (since 1987) and Evansville (since 1983).

The VA is planning to open a 94-bed nursing home facility in Indianapolis by December 1999 that will include a small unit for patients diagnosed with Alzheimer's Disease. The VA is also negotiating with private providers to provide for outpatient medical services in South Bend, Anderson, Lafayette, and Terre Haute.

Indiana Department of Health Facility Survey. The State Department of Health periodically conducts surveys at all licensed health care facilities, including the Indiana Veterans' Home, to determine the facilities' compliance with state health regulations. (410 IAC 16.2-2-2(g)(3)) .

A review of the Home's April 1997 survey reveals that the Home was free of any care-

related deficiencies. The survey revealed three non-care-related deficiencies including (1) Employee orientation was not documented for three of fourteen employees hired since previous survey; (2) The Home failed to maintain a job description in the personnel records of ten of the fourteen newly hired employees; and (3) The personnel files of eight of the fourteen new hires failed to document the required pre-employment physical examination. These deficiencies were addressed by the Home in a plan of correction and corrective action was completed in May 1997.

This survey was in stark contrast to the survey completed in November 1994. According to that survey, the Home was cited for approximately 100 deficiencies. The number of each type of deficiency and examples of them were:

- Direct care (7).
  Examples: Failure to assess cough that eventually was diagnosed as Tuberculosis. Improper use of restraints.

- Kitchen related (23).
  Examples: Dirty and broken kitchen tiles, uncovered foods, greasy surfaces.

- General cleanliness and repair (16).
  Examples: Cracked caulking, discolored tiles, torn, hanging wallpaper.

- Pest control (3).
  Examples: Flies in dining hall, 6 - 20 dead bugs in each light fixture.

- Recreation/activity (9).
  Examples: Activities geared only to mobile residents, insufficient number of planned activities.

- Resident dignity (3).
  Examples: Unmade beds, residents eating meals in hallway using fingers.

- Resident participation in treatment plan (3).
  Examples: Resident who wanted to change doctors was forced to use VA hospital with transportation at own expense. "Do Not Resuscitate" orders issued without documentation or discussion with resident, family, or power of attorney.

- Health hazards in buildings (4).
  Example: Second-hand smoke drifting five rooms away from smokers' lounge.

- Abuse of residents and staff by other residents (8).
  Example: After one resident was attacked by another, they were only separated. The resident's family and physician were not notified until two or three days afterward.

- Medical neglect (5).
  Examples: Resident with significant weight loss who refused to eat was not properly assessed. Medical staff failed to follow up on treatment for diagnosed ailments.

- Infection control (5).
  Examples: No action taken after finding abnormalities in resident's urinalysis. Infection Control Committee minutes and reports document several similar cases, but the Committee took no action.

- Medical Director responsibilities.
  The survey held the medical director responsible for all medical deficiencies.

- Superintendent responsibilities.
  The superintendent was held responsible for the deficiencies overall.

After this survey was completed, the Superintendent retired and the medical director was suspended and is no longer associated with the Home.

Indiana Veterans' Home Advisory Committee.

The Indiana Veterans' Home Advisory Committee was established to "act in an advisory capacity to the [Superintendent of the Veterans' Home] and to the State Health Commissioner in the [Commissioner's] capacity as administrative head of the Administrative Unit for Special Institutions." The Committee is to advise the Superintendent and the Commissioner "concerning ways and means of improving the [Veterans' Home] and the care of the residents in the [Veterans' Home]" (IC 16-19-6-9). Other special institutions administered by the State Department of Health include the Indiana Soldiers' and Sailors' Children's Home, the Indiana School for the Blind, the Indiana School for the Deaf, and Silvercrest Children's Development Center.

The Home Advisory Committee consists of eight members, including one licensed physician, one state legislator from the district in which the home is located, and the director of the Indiana Department of Veterans' Affairs or the director's designee. Members are appointed by the Governor for four-year terms. The Chair and Secretary of the Committee are elected from among the Committee members. The Committee also selects one of its members to serve as a member of the Administrative Unit for Special Institutions. The Committee meets quarterly.

A review of the Committee's minutes from its 1996 and 1997 meetings reveals that the Committee discussed various topics regarding the Home, including the following:

On-going Issues
- Staffing problems for nursing
- Problems in the food service department with "inconsistencies in quality control and menu planning."

Veterans' Home Administration
- Senior staff changes (resignations / retirements and new hires / promotions)
- Staffing updates
- Specific employee problems
- Budgetary items (budget deficit, cost of fuel, cost of contract services)
- Strategic plan updates
- Computer network installation
- Requirement to post notices of public meetings

Residents
- Behavioral problems with two residents requiring discharge
- Two residents discharged themselves against medical advice
- Several medically able residents discharged themselves
- Current census at each meeting
- Monthly newsletter

Medical Programs
- Creation of sub-specialty clinics
- Cooperation with VA hospital and local hospitals
- Respiratory and radiological service improvements
- Current and planned Alzheimer care
- Implementation of a restorative nursing program
- New consultants for substance abuse, psychiatric care, skin care, infectious disease, rehabilitation, and geriatric medicine

Veterans' Organizations
- Support from Veterans' organizations, such as monthly cook-outs, was termed "outstanding"

Other
- State and VA inspections
- Establishment of an employee recognition program
- Events such as the Centennial Celebration, memorial dedications, and a Veterans' expo
- Establishment of an on-site child care center for employees and area residents
- Renovations
- Cable television upgrade

Indiana Veterans' Home Staffing Issues

The major staffing issues confronting the Home are staffing shortages among its nurse aides and licensed practical nurses (LPNs). The Home has experienced a high turnover rate among nurse aides for the past several years. Adding to the retention problem is the fact that the Home is often unable to recruit sufficient applicants to fill existing nurse aide vacancies. In addition, the Home is experiencing problems with recruitment of licensed practical nurses.

Nurse Aide Staff. The Home employs two levels of aides in its nursing department: certified nurse aides (CNAs) and qualified medication aides (QMA). CNAs perform a variety of non-professional duties associated with resident care, such as helping to dress, feed, and bathe residents. CNAs employed at the Home must have either a high school diploma or two years of full-time work experience. Within 120 days of starting employment, nurse aides must successfully complete a training program and pass a written exam in order to become certified. The Home provides in-house training at no cost to nurse aides. The training program must consist of at least 30 hours of classroom instruction and at least 75 hours of supervised clinical experience.

QMAs perform similar duties to CNAs, but are also able to dispense medication. In order to be employed as a QMA, an individual must have at least one year of work experience in patient care and must have successfully completed a qualified medication aide course and exam.

Exhibit 7 shows the current number of authorized, filled, and vacant CNA and QMA positions, as of April 1998. Authorized positions have been reduced in the last two years. In 1996, 33 CNA positions and 18 QMA positions were eliminated to meet the state's targeted hiring level before July 1, 1996. An additional 22 CNA positions and 16 QMA positions were eliminated in December 1997. Twenty-six of the 38 positions eliminated were part-time positions.

Exhibit 7. Authorized, Filled, and Vacant Aide Positions at the Home, as of April 1998.

Certified Nurse Aides (CNAs)	Full Time	Part Time	Total
Authorized	101	2	103
Filled	81	2	83
Vacant	20	0	20
Qualified Medication Aides (QMAs)	**Full Time**	**Part Time**	**Total**
Authorized	22	0	22
Filled	19	0	19
Vacant	3	0	3

Licensed Practical Nurse Staff. Licensed practical nurses (LPNs) perform a variety of duties associated with the comfort and well-being of patients, including assisting in the admission process; helping to bathe and feed residents; dressing wounds; and administering prescribed medications. In order to work as an LPN, an individual must have a valid state LPN license.

Exhibit 8 shows the number of authorized, filled, and vacant LPN positions as of April 1998. Four part-time unbudgeted/unfunded LPN positions were eliminated from the Home's manning table in December 1997.

Exhibit 8. Practical Nurse Positions at the Home, as of April 1998.

Licensed Practical Nurses (LPNs)	Full Time	Part Time	Total
Authorized	38	3	41
Filled	36	3	39
Vacant	2	0	2

Retention and Recruitment of CNAs. Although the Home employs two levels of aides, it is only experiencing retention and recruitment problems with CNAs. According to the Department of State Personnel, the turnover rate for nursing attendants averaged 39% between July 1994 and April 1998. According to the Home, the turnover rate for new CNAs was 51.3% in 1996 and 81.9% in 1997.

Exhibit 9 shows a comparison of CNA turnover rates at various health facilities. It is important to note that CNA turnover is not just a local or statewide problem, but also a nationwide problem. According

to a survey conducted for the American Health Care Association, nurse aides continue to have the highest turnover rate among nursing facility staff. (American Health Care Association, 1997). Turnover information for private health facilities in the Lafayette area was not available. Although the turnover rate at the Home is lower than many other health facilities, it is still a major problem for the Home and has had significant impacts.

Exhibit 9. Comparison of CNA Turnover Rates (1998).

New CNAs at the Home	**81.9%**
Nursing Facilities in the U.S.[1]	96.8%
All CNAs at the Home	**36.7%**
Home Hospital (Lafayette)	68.6%
St. Elizabeth Hospital (Lafayette)	N/A
Wabash Valley Hospital (West Lafayette)	N/A

[1] *Facts and Trends: The Nursing Facility Sourcebook*, 1997.
N/A = Not Available

At one time, the Home only experienced CNA retention problems. However, it currently also experiences recruitment problems and is often unable to recruit sufficient applicants to fill existing CNA vacancies. Although the Home does not have a problem with LPN retention, when an opening occurs, it sometimes has difficulty filling vacant LPN positions.

Factors Contributing to Staffing Shortages.

The following factors have been identified as contributing to staffing shortages:

- Low wages
- Shift schedules
- Low unemployment rates
- Absenteeism
- Working conditions

Low Wages. One of the major factors contributing to retention and recruitment problems is low wages. The starting salary for a CNA at the Home is $6.64 per hour, which was increased by 2% in January 1998. The starting salary for an LPN is $9.47 per hour, which includes a recruitment differential. Also in January 1998, all employees received a 4% to 8% raise, depending upon their salary at the time. Current employees will receive another 4% to 8% raise in January 1999.

Comparison of CNA Salaries. Exhibit 10 shows a comparison of minimum and maximum hourly salaries for CNAs. The Home not only competes for employees with private nursing homes, hospitals, and employment agencies, but also with other service-related industries such as the fast food industry, the airline industry, the hotel industry, and the retail industry. According to an October 1997 article in the trade publication *Contemporary Long Term Care*, "nursing assistants are among the lowest-paid workers in America, averaging $6 to $7 per hour." (Foltz-Gray, 1997) Even with the recent pay increase, minimum and maximum CNA salaries at the Home are still lower than many other health facilities and service occupations in the Lafayette area.

Exhibit 10. Comparison of Hourly Wages for CNAs (1998).

Employer	Minimum Hourly Wage	Maximum Hourly Wage
St. Elizabeth Hospital -Lafayette	$6.00	$8.46
Home Hospital -Lafayette	$6.45	$9.37
CNAs at the Home	**$6.64**	**$9.73**
Private Health Facilities -Central IN[2]	$6.85	$11.20
Nurse Employment Agencies -Central IN[1]	$9.00	$13.50
Service Occupations -Lafayette Area[3]	$9.14	$13.91
Wabash Valley Hospital -W. Lafayette	N/A	N/A

[1] Range of salaries paid by employment agencies.
[2] Range of salaries paid by private health facilities.
[3] *Lafayette Journal and Courier*, March 17, 1998.
N/A = Not Available

Exhibit 11 shows a comparison of average hourly wages for CNAs. (Data in Exhibit 11 is based on 1996 data from *Facts and Trends: The Nursing Facility Handbook* and the 1996 Long Term Care Information System Database from Myers and Stauffer LC.) For comparison purposes, an average growth rate of 4.6% was applied to the 1996 data. While the average CNA salary at the Home is somewhat higher than average salaries in comparable nursing facilities in the U.S. and in this region, it is less than many other facilities that employ CNAs.

Exhibit 11. Average Hourly Wages for CNAs (1998).

Type of Facility	Average Wage
Nursing Facilities-U.S.	$7.28
Nursing Facilities-N. Central U.S.	$7.44
Current CNAs at the Home	**$7.45**
Skilled Nursing Facilities-IN	$7.91
Intermediate Nursing Facilities-IN	$7.93
Hospitals-U.S.	$8.80
Hospitals-N. Central U.S.	$8.87

Source: 1997 Facts and Trends: The Nursing Facility Handbook and the 1996 Long Term Care Information System Database from Myers and Stauffer LC.

Comparison of LPN Salaries. Exhibit 12 shows a comparison of minimum and maximum hourly wages for LPNs. The Home competes for LPNs with private nursing homes, hospitals, and employment agencies. Even with a recruitment differential, the minimum and maximum LPN salaries at the Home are lower than other health facilities in Central Indiana.

Exhibit 12. Comparison of Hourly Wages for LPNs (1998).

Facility	Minimum Hourly Wage	Maximum Hourly Wage
IVH LPNs	**$9.47**	**$13.65**
Home Hospital -Lafayette	$9.58	$14.03
St. Elizabeth Hospital -Lafayette	$10.00	$14.10
Wabash Valley Hospital -Lafayette	$10.37	$16.99
Private Health Facility -Central IN[2]	$13.00	$24.00
Nurse Employ. Agencies -Central IN[1]	N/A	$24.00

[1] Range of salaries paid by employment agencies.
[2] Paid by one health facility.
N/A- Not Available

Exhibit 13 shows a comparison of average hourly wages for LPNs. For comparison purposes, an average growth rate of 3.2% was applied to the 1996 data. The average LPN salary at the Home is the lowest among other health facilities in the state and the U.S..

Exhibit 13. Average Hourly Wages for LPNs (1998).

Type of Facility	Average Wage
Current LPNs at the Home	**$12.09**
Nursing Facilities-N. Central U.S.	$12.18
Hospitals-U.S.	$12.77
Nursing Facilities-U.S.	$12.83
Hospitals-N. Central U.S.	$13.05
Skilled Nursing Facilities-IN	$15.21
Intermediate Nursing Facilities-IN	$15.42

Source: 1997 Facts and Trends: The Nursing Facility Handbook and the 1996 Long Term Care Information System Database from Myers and Stauffer LC.

In addition to paying comparable or higher starting salaries, private health facilities are often able to pay bot CNAs and LPNs sign-on bonuses as well as retention, referral, attendance, and safety bonuses. Private facilities also pay salary differentials for evening, night, and weekend shifts. Some facilities will also pay higher salaries in lieu of benefits. Due to current state personnel policies, the Home is unable to pay these same incentives.

The Impact of Shift Schedules. Another factor contributing to CNA and LPN staffing shortages is shift schedules. The comprehensive care and assisted living units at the Home must be staffed 24 hours a day, seven days a week. To find individuals willing to work evening, night, and weekend shifts is difficult due to competition with other facilities that pay shift differentials. These shifts are often staffed with CNAs and LPNs from employment agencies.

Low Unemployment Rates. A low unemployment rate contributes to CNA staffing shortages because a low unemployment rate shrinks the pool of potential applicants. As noted in an October 1997 *Contemporary Long Term Care* article, "Frontline shortages [in long-term care] are a cyclical problem. They come and go depending on the state of the economy in a particular region or nationally." (Foltz-Gray, 1997) In December 1997, the unemployment rate in the Lafayette metropolitan statistical area was 2.5% while the rate in Tippecanoe County was 2.4%. These rates compare to a 3.4% unemployment rate for the state, a 4.6% rate for neighboring Illinois, and a 4.4% rate for the United States.

Health care facilities are not the only employers experiencing recruitment problems. According to a labor market study conducted by Indiana University

and Greater Lafayette Progress Inc., "73 percent of employers find it difficult to recruit qualified workers living within a one-hour commute of Greater Lafayette." (Lafayette Journal & Courier)

High Rate of Absenteeism. Another factor contributing to staffing shortages is the high rate of absenteeism among CNAs and LPNs. On average, 15 employees from the Nursing Department call in and do not report to work within a 24-hour period. According to the Home, many absences are related to child-care issues. Although there is a child care facility on the Home grounds, it is not available for employees who work the night and weekend shifts. Even with an employee discount of approximately 30%, child care costs between $200 and $380 per child per month, depending on the age of the child. For a CNA with one child, child care expenses could account for 13% to 35% of pre-tax income.

Absenteeism is also due to approved leaves of absence, such as short-term disability, family and medical leave, union business, in-service education, vacation, and sick leave. At any given time, the Home has an average of 12 employees out of 141 from the Nursing Department on some type of leave. This average does not include employees on long-term disability leave, as the Home is able to replace those employees.

Working Conditions. Another factor contributing to CNA retention and recruitment problems is the physically demanding and stressful conditions under which CNAs work.

Impacts of Staffing Shortages. Staffing shortages have increased expenditures for overtime, employment agency staff, and training; resulted in a reduction in the resident census; and affected resident care. In order to operate with sufficient staff, provide quality care, and meet state long-term care regulatory standards, the Home must rely on overtime and nurse employment agencies. The Home spent approximately $105,000 on CNA overtime and approximately $142,000 on LPN overtime in FY97. In FY98, overtime costs were projected to be approximately $112,000 for CNAs and $157,000 for LPNs. The additional overtime expenditures have been financed primarily with money from vacancies due to a hiring lag and from reduced overtime expenditures in other departments.

Employment agency costs were approximately $346,000 for CNAs and approximately $76,000 for LPNs in FY97. The additional employment agency costs were financed with interdepartmental transfers from other special institutions administered by the State Department of Health. In FY98, employment agency expenditures were projected to be approximately $317,000 for CNAs and $94,000 for LPNs. The additional employment agency expenditures have been financed with funds available due to a reduction in expenditures for materials, a virtual elimination of expenditures for equipment, and a reduction of overtime in other departments. This year's mild winter also freed up additional funds that had been allotted for fuel.

Exhibit 14 shows a comparison of CNA and LPN hourly costs for state employees and employment agency staff. Hourly wages paid to state employees were significantly lower than both hourly overtime wages and hourly employment agency costs. When the cost of benefits was included in CNA state employee costs, the costs were still lower than employment agency costs. For LPNs, the costs of wages and benefits were lower than both overtime and employment agency costs. This discrepancy was especially true for evening, night, and weekend shifts when hourly employment agency costs were generally higher.

High CNA turnover has increased training costs. As noted above, the Home provides in-house training at no cost to nurse aides. In addition, the Home pays the $50 certification exam fee for each new nurse aide.

Staffing problems have also resulted in a reduction in resident census at the Home. In November 1997, the Home decided to reduce its resident census by 20 to 25 through attrition and delayed admissions. Admission delays occurred only when it would not create a serious medical or financial problem for the applicant and his or her family. Once staffing problems are alleviated, the Home hopes to increase its census to approximately 300 in comprehensive care and 125 in assisted living and self-care.

In addition, staffing shortages have negatively affected resident care. "Studies have shown that probably the most important thing in residents'

overall well-being in a nursing home is their relationships with staff." (Lang, Aug. 96) Constant turnover and employment agency staff result in a loss of continuity of care for residents and a less

Exhibit 14. Comparison of Hourly Costs for CNAs and LPNs

	State Wages	State Wages Plus Benefits	State Overtime Wages[1]	Employment Agency Costs[2]
CNA	$6.64 - $9.73	$10.27 - $13.98	$9.96 - $14.60	$9.50 - $19.50
LPNs	$9.47 - $13.65	$13.66 - $18.67	$14.21 - $20.48	$23.50 - $32.50

[1] Overtime is paid at time and a half of current pay after working forty hours in a week.
[2] Range paid to employment agencies.

experienced staff. Based on the March 1998 Department of State Personnel manning table, approximately 38% of CNAs had about a year or less experience on the job.

Proposals to Address Staffing Shortages.

The Home has developed a number of proposals to address staffing shortages. Several of these proposals have already been implemented. The proposals include the following:

- Additional salary increase over current state personnel package
- Shift differentials
- Four-day work week
- Upward mobility for CNAs
- Providing a selection of benefits from which to choose
- Pay for unused sick leave
- Operation as a clinical training site
- Improved orientation and training
- Light-duty work assignments
- A lift-free environment

Additional Salary Increase Over Current State Personnel Package. The Home has proposed a 4.5% pay raise for all nurse aides to become effective July 1, 1998. This proposal was based on a recommendation made by the Department of State Personnel in October 1997. The initial 1998 starting salary for a nurse aide would remain at $6.64 per hour. However, once a nurse aide becomes certified, his or her salary would increase to $6.94 per hour. It is hoped that a pay raise upon certification will help retain newly certified nurse aides. This 4.5% pay raise would also apply to current CNAs and QMAs.

Based on the March 1998 Department of State Personnel manning table, a 4.5% raise for all currently employed CNAs and QMAs would cost approximately $82,000 in FY99, including fringe benefits. The cost of the pay raise when all positions are filled would be approximately $95,000, including fringe benefits. Money for this pay raise would be reallocated within the Home's budget. This pay raise must be approved by the State Budget Agency and the Governor.

If a 4.5% pay raise for nurse aides is implemented in July 1998, the January 1999 state employee pay raise for all current CNAs and QMAs would cost approximately $43,000 more, including fringe benefits, for the last half of FY99. The additional cost if all positions are filled would be approximately $51,000, including fringe benefits.

Shift Differentials. Another pay increase proposal is to provide shift differentials for CNAs and QMAs who work evening, night, and weekend shifts. Since these shifts are often the most difficult to fill, a higher salary may be an incentive for nurse aides to work these shifts. The Home has not yet made a formal proposal regarding what differential would be paid. An estimated 104 positions would be affected. A higher per hour wage for evening, night, and weekend shifts would likely still be cheaper than paying an employment agency, since employment agency costs are higher for these shifts.

Four-day Work Week. Another proposal to address staffing shortages is to change the work week from 7.5 hour shifts five days a week to 9.5 hour shifts four days a week for CNAs, QMAs, and LPNs. It is hoped

that a shorter work week will help with retention and recruitment as well as absenteeism. The extended shifts would also help with staff overlap during busy times, such as meals, and with continuity of care for the residents. This proposal would require each CNA and LPN to work 0.5 hours of overtime each week, which would be paid at the regular salary.

This proposal would affect 101 CNA, 22 QMA, and 38 LPN positions. According to the Home, a majority of employees are in favor of this proposal. For those employees who are unable to work 9.5 hour shifts, the Home has proposed that a predetermined number of positions be kept at the 7.5 hour shifts. These positions would be filled through lateral transfers based on seniority. This proposal has to be approved by both the State Department of Health and the State Department of Personnel.

Upward Mobility for CNAs. Another proposal is to provide upward mobility for CNAs by converting some CNA positions to QMA positions. The total number of aide positions would remain the same. As stated above, there are 101 full-time CNA positions, but only 22 full-time QMA positions. It is not currently known how many additional QMA positions would be created. According to an article in the trade publication *Nursing Homes: Long Term Care Management*, Genesis Eldercare, a nursing facility in Pennsylvania, "reported dramatic reductions in turnover and improved morale" after implementing a career ladder for nurse aides. (Pillemer, March 1997)

Selection of Benefits. Another proposal is to provide for the selection of benefits. This option would give all employees more flexibility to choose those benefits that would be most beneficial to them. The expanded selection of benefits would include additional child care options, such as a larger discount at the child care facility on campus or making child care available 24 hours a day, seven days a week. The total cost of the benefits package would remain the same.

Pay for Unused Sick Leave. An additional proposal is to pay all employees for unused sick leave when they separate from state employment. Currently, state employees are not compensated for accrued sick leave. Paying for unused sick leave may decrease absenteeism because many employees may view sick leave as a lost benefit if it is not used before they leave. The cost of this proposal depends on the number of sick days accrued by each employee and each employee's actual hourly wage.

Clinical Training Site. Another proposal is to operate the Home as a clinical training site for external nurse aide students. The Tippecanoe School Corporation offers nurse aide classes. In addition, the Lafayette campus of Ivy Tech is approved for nurse aide training, but does not currently offer classes. According to the State Department of Health's rules, individuals enrolled in nurse aide training programs must complete at least 75 hours of clinical work. Although this proposal would not increase staff capabilities due to required supervision and monitoring, it may facilitate future recruiting of these students.

Training and Orientation. Another proposal that the Home is working on is to improve orientation and training to create a more positive working environment. According to Dr. Karl Pillemer, a gerontologist at Cornell University, orientation is an important aspect of recruitment because employees "often leave during training - as many as 80%, in some cases [and that] much of that turnover occurs because the orientation is not clear or well-organized." (Peck, June 1995)

Light-Duty Work Assignments. Another proposal is to provide light-duty work assignments for injured employees who are not able to work at full duty. This proposal has already been fully implemented and has helped to return injured employees to their regular duties and shifts more quickly. Under this proposal, certain duties are assigned to injured employees during an 11 a.m. to 7 p.m. shift. Prior to the implementation of this proposal, injured employees were assigned office duties during the 7 a.m. to 3 p.m. shift. This did not provide incentive for employees to return to their regular duties and shifts.

Lift-free Environment for Nurse Aides. Another proposal that has been implemented is providing a lift-free environment for nurse aides. The American Legion recently helped the Home purchase six lifts to help nurse aides lift residents. These lifts reduce the amount of heavy lifting that has to be done by aides, reducing the risk of back injuries. The lifts also reduce the amount of time it takes to lift residents as well as increase the comfort and safety of residents. It is hoped that these lifts will reduce time lost to

injuries, as well as improve retention and recruitment.

The following options could help reduce the amount of overtime and/or use of employment agency staff.

- Add new staff
- Reestablish a float pool of part-time staff
- Implement mandatory overtime
- Use Indiana National Guard personnel

Add New Staff. Based on the Home's review of employment agency use, the Home estimates that in order to eliminate employment agency use completely, 30 additional CNA positions and six additional LPN positions would need to be added.

Float Pool. One proposal is to reestablish a float pool of part-time and/or intermittent staff to cover for absent staff and to help during busy hours. Use of part-time and/or intermittent staff would be more cost-effective than employment agency staff as part-time and intermittent staff do not receive benefits. The Home used a float pool of part-time employees until all unfunded/unbudgeted positions were eliminated in December 1997. Loss of the float pool added to overtime and employment agency costs. The previous float pool consisted mainly of nursing students willing to work nights and weekends.

Mandatory Overtime. One proposal that would help reduce employment agency use is to implement a mandatory overtime policy. The Home currently has a voluntary overtime policy, which has not been as successful as the Home would like. Mandatory overtime is not a highly desirable option due to the increased overtime costs; the possible negative impact on retention and recruitment; and the resistance of the American Federation of State, County, and Municipal Employees (AFSCME).

Use the Indiana National Guard. The Home is exploring the possibility of using Indiana National Guard personnel to supplement Home's current staff during weekend and summer drill periods. If these personnel are paid by the National Guard and meet certification requirements, they could help reduce both overtime and employment agency costs. Currently, however, the Home understands that the National Guard is not interested in this activity.

Indiana Veterans Home Participation in the Medicaid Program

Potential Additional Revenue from Participation in the Medicaid Program.

The Indiana State Veterans' Home does not participate in the Medicaid Program. Although the amount of federal revenue that could be generated from the Home's participation in the Medicaid Program is not known, additional federal revenue estimates range from $1.5 million to $2.9 million annually.

The estimated range is based on an FY97 average daily cost per resident of $135.56. Of this amount, the average resident contribution was $23.56, the average VA per diem was $39.00, and the average contribution of state funds was $73.00 per day. The additional estimated revenue of $1.5 million to $2.9 million is also based on the following assumptions: (1) between 50% and 100% of the 273 comprehensive care residents might be eligible for the Medicaid Program; (2) residents would be permitted to retain $125 per month in income for personal needs; (3) the VA per diem would be deducted from the federal Medicaid payments; and (4) a federal matching percentage rate of 61.1% would be available.

The additional federal revenues may be understated to the extent that the average daily costs described above also include lower cost assisted living and self-care residents. Since the lower cost assisted living and self-care residents would be ineligible for the Medicaid Program, the average cost reimbursable under the Medicaid Program would actually be greater for comprehensive care residents than the average daily costs described above.

Impact of Medicaid Program Requirements on Residents.

The principal eligibility requirements that affect program recipients, aside from level of care, are the income and resources of the individual. A perceived major disadvantage of participation in the Medicaid Program is that residents of the Home, and a spouse if one exists, would be required to be impoverished much beyond their current levels in order to be eligible. However, federal Medicaid or VA requirements do not mandate levels of impoverishment much more severe than what the residents are currently subject to at the Home. States have considerable flexibility in establishing income and resource standards. The State Veterans' Home could participate in the Medicaid Program with limited impact on the resources and incomes of either the resident or a spouse remaining in the community. The following sections discuss federal requirements and state options with respect to income and resource limitations.

Residents' Income Protected for Personal Needs

Current Practice at the Indiana State Veterans' Home -- Personal Needs Allowance. Residents at the Indiana Veterans' Home are expected to contribute toward their care and maintenance to the extent of their ability to pay. Residents are permitted $130 per month for personal needs. This amount is considered by the Home as belonging to the resident and is not required to be contributed toward the cost of the resident's care. Income above the personal needs allowance (PNA), however, is required to be contributed toward the resident's care and maintenance.

Resident fees at the Home are calculated based on the previous fiscal year's average costs per resident as provided in Indiana statute. Residents contribute their entire income in excess of their personal needs allowance. VA pensions, work pensions, social security payments, and any other income are included as income. The balance of the cost of care is paid from the State General Fund and a VA per diem made to the Home on behalf of the veteran (currently $40 per day for comprehensive nursing care and assisted living and $17.78 per day for domiciliary care).

Requirements of the Federal Medicaid Program. Federal Medicaid statutes require that **non-**veteran Medicaid recipients in private or non-profit nursing facilities must be allowed a PNA of at least $30 per month. States may, however, allow individuals to retain more than the federal minimum for personal needs. There is no federally mandated upper limit. Indiana, historically, has had a $30 allowance for individuals in nursing facilities, but recently has promulgated rules to raise the allowance to $35 per month.

A different situation exists for a Medicaid-eligible

veteran with no dependents who is in a nursing facility that is **not** a state Veterans' home. The veteran's total VA pension amounts are reduced to a maximum payment to the veteran of $90 per month. However, the entire $90 is exempt from state Medicaid rules for personal needs allowances.

In a third situation, in determining the amount of income that must be contributed toward the care of a Medicaid-eligible veteran in a state Veterans' home, $90 of the veteran's pension is not considered countable as income. The state-determined PNA ($35 in Indiana) may be protected for the veteran, as well. The balance of the veteran's income must be contributed toward care and maintenance. Consequently, the amount that can be reserved for the veteran's personal use can effectively be $125 per month with no statutory change in the personal needs allowance offered to all Medicaid recipients ($90 +$35 = $125).

Practice in Other States. Out of 45 states with state veterans' homes, 17 participate in the Medicaid Program. Ten of the 17 states provide PNAs for their veterans greater than the allowance provided non-veteran Medicaid recipients in private nursing facilities. Of the ten states with greater allowances for their veterans, six provide an allowance of $90 per month, while income allowances in three other states ranged from $130 to $160 per month. California is unique in that it requires veterans in the state veterans' home to pay a fixed percentage of their income for their care: 65% for intermediate nursing care with a $2,300 per month maximum contribution; 70% for skilled nursing care with a $2,500 per month maximum contribution. Allowances for the 17 states participating in the Medicaid Program with their state veterans' homes are compared in Exhibit 15.

Resource Limits for Residents

Current Practice at the Indiana State Veterans' Home -- Resource Limits. An individual is expected to contribute toward his or her own care and maintenance to the extent of the individual's ability to pay. This is true in both the Medicaid Program and the Indiana State Veterans' Home, although the standards differ. In addition to income, the resources owned by an individual are considered by both Home and Medicaid as being available to the resident for his or her care and maintenance.

Exhibit 15. Comparison of Personal Needs Allowances (PNA) for Veterans and Non-Veterans in Medicaid Programs.

State	Monthly PNA: Med'd-Eligible Vet'n in State Veterans' Home	Monthly PNA: Med'd-Eligible Non-Veteran in Private Nursing Facility
California	% of Income *	$30
Colorado	$90	$34
Connecticut	$90	$30
Florida	$30	$30
Iowa	$90	$30
Maine	$130 **	$40
Maryland	$40	$40
Montana	$90	$40
New Mexico	$90	$30
New York	$140***	$50
N. Dakota	$40	$40
S. Carolina #	$30	$30
Tennessee	$30	$30
Vermont	$40	$40
Virginia #	$30	$30
Washington	$160	$43
Wisconsin	$90	$40

* Intermediate Nursing Care (65% of income goes to care with $2,300/mo. maximum; Skilled Nursing Care (70% of income goes to care with $2,500/mo. maximum)

** Maine: $40 (minimum) + $90 (if vet receives Aid & Attendance pension (A&A))

*** New York: $50 (minimum) + $90 (if vet receives A&A or Uncompensated Medical Expenses (UME) pension benefits)

Currently allowing veteran to retain entire A&A and UME benefits. However, Balanced Budget Act of 1997 makes A&A and UME in excess of $90 countable as income making these subject to change.

IC 10-6-1-8 provides that each resident at the Indiana Veterans' Home is liable for 100% of the cost of the individual's care and maintenance. Residents are, however, permitted to keep $3,000 in liquid assets with the excess expected to be contributed toward the costs of care.

Also by statute, the liability for costs of care and maintenance constitutes a lien upon the real property of the resident. By practice, however, the Home does not aggressively pursue real property valued at less than $8,500. The Home also does not pursue recovery of real property while a spouse or dependent is alive.

Regarding the determination of the amount of resources to be protected for a spouse remaining in the community, the Medicaid spousal impoverishment guidelines are generally followed albeit with considerable flexibility exercised by the Home. For example, the Home will request a budget from the community spouse taking into account expected future needs. Depending on the outcome of the budget, resources may be shifted either from the veteran to the community spouse, or from the community spouse to the veteran for contribution toward the veteran's care. Decisions are made at the discretion of the Home.

Federal Medicaid Requirements for Resources (Recipients in Nursing Facility). In determining eligibility for Medicaid, federal requirements allow an individual to have countable resources in the amount of $2,000 for an individual ($3,000 for a couple, if both are in a nursing facility). Excluded from countable resources are:

- A home of any value, as long as it is used as the applicant's principal place of residence;
- Up to $2,000 of household goods and personal effects;
- An automobile with a market value of $4,500 or less;
- The cash surrender value of life insurance to the extent that the total face value of all life insurance policies does not exceed $1,500;
- Burial spaces and up to $1,500 per person for burial expenses (reduced by the face value of any excluded life insurance policies);
- Certain amounts of property that are essential to self-support; and
- Housing assistance provided under certain programs.

(Congressional Research Service; p. 203)

Indiana's Medicaid Requirements for Resources (Individuals and Couples in Nursing Facility). Indiana allows only $1,500 in countable resources for individuals ($2,250 for a couple, if both are in a nursing facility). Exclusions from countable resources match the federal requirements.

Resource Limits for Community Spouses

Federal Medicaid Spousal Impoverishment Provisions. When a Medicaid recipient is in a nursing facility and the spouse remains in the community, federal provisions prevent the forced impoverishment of the community spouse in order to gain Medicaid eligibility for the individual in the nursing home.

Initial Eligibility Determination (Medicaid): Upon the entrance of one of the spouses into a nursing home, an initial eligibility determination is made by performing the following calculation. The amount of the couple's total resources are combined. Items excluded from the couple's total resources include (1) a home of any value; (2) household goods; (3) an automobile of any value; (4) burial funds; (5) income-producing property; and (6) real property. The amount of resources protected for the community spouse equals the greater of (1) one-half of the combined total of resources at the time the institutionalized spouse entered the nursing home up to a maximum of $80,760 for FFY98; or (2) the state-established standard (currently $16,152 in Indiana). Both the maximum and the state-established standard amounts are adjusted annually by the Consumer Price Index.

When the community spouse's half of the combined resources is less than the state standard, the spouse in the nursing home may transfer resources to the spouse sufficient to meet the state-established standard. If, on the other hand, the community spouse's half of the combined resources is greater than the maximum allowed the community spouse, the community spouse must reduce the excess resources to the $80,760 maximum before the institutionalized spouse can be determined eligible for Medicaid. The couple is then required to reduce resources in excess of $1,500 (in Indiana's case) and any resources in excess of the community spouse's maximum

allowable amount (currently $80,760) to become eligible for Medicaid. Examples are provided below.

Example 1. Treatment of Resources Under Medicaid and at Indiana State Veterans' Home.

Medicaid Spousal Impoverishment Provision.

Couple has $20,000 in combined resources. Community spouse is entitled to the greater of (A) the state standard (currently $16,152) or (B) one-half of the combined resources (=$10,000).

Institutionalized Spouse		Community Spouse	
		(A) State Standard =	$16,152
(C) ½ of $20,000 =	$10,000	(B) ½ of $20,000 =	$10,000
		Difference (A-B) =	$6,152
(D) Institutionalized spouse can transfer up to $6,152 to the community spouse.	($6,152)	**After transfer, community spouse has $16,152 in resources ($10,000 + $6,152). These resources are protected for the community spouse.**	**$16,152**
(E) Remaining resources of the institutionalized spouse (C-D)	$3,848		
(F) Resource limit:	$1,500		
Amount of resources that must be reduced (E-F)	$2,348		

Indiana State Veterans' Home.

The Home generally follows the Medicaid Spousal Impoverishment guidelines, albeit with additional flexibility. According to personnel at the Home, the spouse is required to formulate a budget of expected needs. If it is determined that the community spouse needs additional resources, the spouse in the Home may transfer resources to the community spouse. This can also occur in the reverse. If it is determined that the community spouse has more than enough resources, the community spouse can be requested to contribute to the institutionalized spouse's care.

Example 2. Treatment of Resources Under Medicaid and at Indiana State Veterans' Home.

Medicaid Spousal Impoverishment Provision.

Couple has $40,000 in combined resources. Community spouse is entitled to the greater of (A) the state standard (currently $16,152) or (B) one-half of the combined resources (=$20,000).

Institutionalized Spouse		Community Spouse	
		(A) State Standard =	$16,152
(C) ½ of $20,000 =	$20,000	(B) ½ of $20,000 =	$20,000
		Greater =	$20,000
(F) Resource Limit:	$1,500	**These resources are protected for the community spouse.**	**$20,000**
Amount of resources that must be reduced. (E-F)	$18,500		

Indiana State Veterans' Home.

The Home generally follows the Medicaid Spousal Impoverishment guidelines, albeit with additional flexibility. The spouse is required to formulate a budget of expected needs. If it is determined that the community spouse needs additional resources, the spouse in the Home may transfer resources to the community spouse. This can also occur in the reverse. If it is determined that the community spouse has more than enough resources, the community spouse can be requested to contribute to the institutionalized spouse's care, same as in Example 1.

Once the eligibility determination is finalized, the community spouse's resources are considered to be the community spouse's and are no longer attributable to the institutionalized spouse. This is even true upon the death of the institutionalized spouse in that the community spouse's protected assets are not considered part of the Medicaid spouse's estate and, thus, are not subject to recovery by Medicaid. Only those assets that were included in the institutionalized spouse's probate estate are subject to recovery after the surviving spouse's death. (In addition, resources protected under the Indiana Long Term Care Program are not subject to recovery from the recipient's estate.)

Post-eligibility Treatment of Income (Medicaid). Income of the community spouse can not be considered as income of the nursing home spouse unless that income is made available to the nursing home spouse. Once eligibility is determined, a post-eligibility process is conducted to determine (1) how much of the institutionalized spouse's income is protected for the community spouse, and (2) how much the spouse in the nursing facility is required to pay toward the spouse's own care. A procedure, similar to the resource protection provisions above, is used to determine the amounts of income that can be protected. In essence, income between $1,327 and $2,019 per month can be protected for the spouse in the community (these values are annually adjusted by the Consumer Price Index). The community spouse's own income is not required to be contributed to the institutionalized spouse's costs of care.

Treatment of Income (At the Home). The amount of veteran's income that must be contributed toward the veteran's care is determined in a manner similar to the determination of resources that must be contributed to the Home and the amount that is protected for the community spouse. Again, Medicaid guidelines are generally followed, albeit with considerable discretion by the Home. The community spouse is requested to develop a budget, taking into account expected future needs. The Home may, with the consent of the veteran, allocate a portion of the veteran's income to the community spouse. However,

the community spouse's income would never be required to be contributed toward the veteran's cost of care.

Of the 273 Home residents in comprehensive care, 42 have a spouse in the community. Nine couples reside in the Home: eight couples in comprehensive care, and one couple with one member in comprehensive care and the spouse in a residential unit.

Potential Costs to the Home for Participation in Medicaid. Participation in the Medicaid Program could add some administrative costs. Additional personnel or equipment may be needed. However, in phone conversations with other state veterans' homes participating in Medicaid, some experienced additional administrative costs and others did not. Closer analysis would be required to determine the extent of these costs that might be incurred at the Home. Additionally, although the Home's staff believed that current nursing staffing levels were probably sufficient for Medicaid certification, this potential cost would also need to be examined in closer detail.

Conclusion. States are granted considerable flexibility in designing their Medicaid programs, especially for veterans in state veterans' homes. The income protected for a Medicaid-eligible veteran need be only $5 per month lower than currently allowed at the Home.

In addition, the spousal impoverishment provisions of the Medicaid program provide considerable protection of both income and resources for spouses remaining in the community. In effect, from $16,152 to $80,760 in resources, in addition to a house and a car and other resources, are protected for the community spouse. From $1,327 to $2,019 in monthly income may also be protected for the community spouse.

On the other hand, the resources allowed the single veteran would be only $1,500 for Medicaid eligibility (assuming Indiana did not change its statewide resource limit) compared to the $3,000 currently allowed at the Home. (For a couple on Medicaid, this resource limit is $2,250 in Indiana.)

Although Medicaid participation could result in some additional administrative costs, participation could also mean significant additional federal revenue with minimal impact on the welfare of the residents. In fact, residents could be made no worse off, on balance, and perhaps better off, by increased investment in capital facilities, programming, and other improvements affecting the general quality of life of the veterans. Improvements that offset the loss of residents' resources can be financed from a portion of the new federal revenues resulting from participation in the Medicaid Program. Closer examination of the potential costs and benefits from participation in the Medicaid Program would appear to be warranted.

Other Issues Confronting the Indiana Veterans' Home

Procurement. IVH expenditures could be reduced in certain areas. One area is the Quantity Purchase Award (QPA). QPAs are contracts granted by the Department of Administration (DOA) to the lowest price vendor capable of supplying the necessary goods and services. In theory, the QPA bidding process ensures that quality goods and services are being acquired at the lowest possible price.

Because processing QPAs is somewhat tedious, cumbersome, time-consuming and costly, some vendors with good reputations, prices, and products choose not participate in the bidding process or cannot afford the administrative overhead of doing business with the State. Furthermore, local vendors dealing directly with the Home can often quote prices substantially lower than the QPA source.

Examples include QPAs for supplies for nursing, housekeeping, office supplies, automation and communications equipment, as well as commodities such as natural gas. Because of dramatic fluctuations in natural gas prices, substantial savings may be realized by contracting directly for supplies much earlier or later than the contract associated with a QPA.

For example, in April 1997, the Home contracted with Proliance, a direct marketer of natural gas. The Home cost for this natural gas was $2.39 per decitherm, plus $.60 per decitherm transport fee for a total of $2.99 per decitherm at the burner tip. The natural gas cost was at the bottom of the market when the Home bought in. The least expensive QPA cost for this commodity was $3.11 per decitherm at the burner tip. Approximately $10,000 in natural gas costs could have been saved. The DOA waited for approximately six weeks before locking-in a price, at which time the market had gone up.

For 1998, IVH was required to use the QPA and any deviation from the QPA had to be approved in writing.

Below is a list of the potential advantages of entering into an agreement with a prime vendor versus the current QPA procurement system. A prime vendor contract is a contract in which an entity purchases most or all of a particular item from one vendor. It is possible that this move would require some legislative changes to the current procurement law.

Ordering. All food products ordered through a prime vending system is completed through a computer system which eliminates the current paper process. According to the Home, the computer system necessary for this process would be provided by and set up by the vendor. All training would be provided by the vendor as well. The current procurement system requires food products to be ordered as much as three months in advance. According to the Home, the prime vending contract allows orders to be submitted one to two weeks in advance, reducing the amount of money dedicated to inventory cost.

Inventory Control. Ordering food products one or two weeks in advance and receiving deliveries one or two times per week would ensure a fresher product and would reduce inventory costs. The amount of space required to maintain inventories would also be reduced. Ordering less product more frequently also eliminates the potential for spoilage and food products becoming outdated.

Production Management. Ordering food products more frequently allows for menu modification as necessary. Currently, the Home orders up to three months in advance which limits the ability to modify menus. Using a prime vendor may also prevent waste. Orders could be placed for the exact amount needed during the next menu cycle. The Home could receive a credit for inferior or outdated food.

Streamline. Using a prime vendor would mean one contract for food. The current QPA process may require contracts with multiple vendors, depending on who has been awarded the QPA bid. With a prime vendor, the ordering process would be streamlined.

Cost Management. A significant savings could be anticipated by using a prime vendor. The current QPA system allows little opportunity to purchase specialized food products for geriatric consumers with special needs, such as swallowing disorders, chewing limitations, and other disabilities associated with the aging process. The prime vendor source has the potential to save time and money, and produce higher quality food service. Before any decision is made regarding this new approach, a detailed cost

study would be necessary.

Veterans' Hospital Experience With a Prime Vendor. The federal Veterans' Hospital in Indianapolis uses a prime vendor contract for its food services (Alliant Foods). Data on certain costs related to food service prior to the use of a prime vendor and after one year's experience with the prime vendor are listed in Exhibit 16.

Exhibit 16. Cost Comparison with Prime Vendor.

Year	Wages	Subsistence/ Supplies	Cost per Meal
FY96	$2,853,184	$549,202	$2.67
FY97	$2,721,525	$412,957	$2.01
FY98 *	$2,340,512	$390,635	$1.67

* Projected

The use of a prime vendor resulted in the following changes. First, the time spent by employees doing inventory before the prime vendor was approximately 40 hours per week. With the prime vendor, the time spent was reduced to four hours per week. Second, the time spent ordering before the prime vendor was approximately 12-16 hours per week. With the prime vendor, this time was reduced to approximately 1-1.5 hours per week.

Ordering from a prime vendor resulted in less waste and loss from spoilage of food since deliveries are made on a weekly basis rather than ordering three months in advance as required by the previous system. Storage space had to be available to contain the large amounts of stock on hand. Also, any problems with discrepancies and/or damages were easily corrected by fax, phone, or e-mail, usually within two weeks. Under the previous ordering procedures, any discrepancies or damages usually took 15-30 days minimum to clear up. In addition, using a prime vendor reduced the number of order errors. Further, with more frequent deliveries, the Hospital is able to order the correct stock and quantities needed.

Other Examples of Procurement Procedures. The federal government allows deviations from normal procurement procedures under certain circumstances. For example, when cost savings would be more than 10% of what the normal procedure would cost, approval could be obtained as long as Procurement was satisfied that it was an equivalent product. Indiana has a similar law--IC 4-13.4-5-7, Special Procurement. It reads in part:

Notwithstanding any other provisions of this article, the Commissioner [of the Department of Administration] may make, or authorize others to make, special procurements under any of the following circumstances: ... when there exists a unique opportunity to obtain supplies or services at a substantial savings to the state.

However, "substantial" is not defined. According to the Deputy Commissioner of DOA, while substantial savings is not defined, special procurements are dealt with on a case-by-case basis.

The DOA is opposed to any cost-sharing agreement, such as the Home "piggybacking" on the prime vendor agreement that the federal Veterans' Hospital has, because it dilutes the purchasing power of the State. Also, the total volume to be purchased under the existing QPA would be reduced, thus potentially increasing the unit price for a particular item.

However, the DOA is in the process of testing the concept of a prime vendor contract with LaRue Carter Hospital for the provision of food service. This test of a prime vendor contract does not include the federal government. However, it is too early to determine the results.

Need for an Alzheimer Building. The Indiana Veterans' Home's current Alzheimer and dementia care unit is located on the fourth floor of the MacArthur Building. Currently, the Home has no ground-level units designed for comprehensive care residents.

Private sector facilities that serve Alzheimer/dementia residents are building one-story, ground-level buildings because they are safer, i.e., no concern about residents falling down stairs, and because an open service center area (as opposed to the traditional hospital-style design units) is more acceptable and therapeutic for this type of resident.

The 1997 General Assembly appropriated $4.95

million from the Veterans' Home Building Fund for the construction of a new 48,000 gross square feet (gsf), one story Alzheimer Building, with courtyards housing all three stages of Alzheimer's. This construction project has been delayed, pending the completion of a needs assessment. The original plans for the building called for a minimum of 32 beds and a maximum of 64 beds. The original cost for this building was estimated to be about $10 million. Through various other studies, the $10 million was reduced to about $8.655 million for 48,000 gsf, housing all three stages of Alzheimer's.

The architectural plans of the proposed building lead the Home to consider housing third stage Alzheimer's patients on Pyle III (the third floor of Pyle Hall). This would eliminate 9,000 gsf of the proposed 48,000 gsf Alzheimer building. At $225 per gsf, this would reduce the cost by $2.025 million from the $8.655 million cost estimate. The remaining 39,000 gsf could be built to house 64 first and second stage Alzheimer's patients at a cost of $6.63 million, or $170 per gsf. By completing 32 beds and "roughing" in 32 beds (i.e., completing all wiring, load bearing walls, and electrical work, but no furnishing or fixtures), the Home could save an additional 25%, or $1.657 million. The final cost would equal $4.973 million.

The courtyards would add an estimated $500,000 to the $4.973 million. This amount could be reduced, depending on allowed substitutions of certain building materials. The courtyards would be the last to be constructed.

Depending on the results of a needs study, the Home may reopen its 50-bed, 17,000 gsf MacArthur II nursing unit. This unit can house 50 comprehensive or intermediate care patients, or 30 first and second stage Alzheimer's patients. A cost analysis, in Appendix 1, compares the estimated start-up and 12 month operating costs of the proposed new facility with the option of reopening MacArthur II (the second floor of MacArthur) as a first and second stage Alzheimer's unit with 17,000 gsf. The total operating and start-up costs for the new Alzheimer Building are estimated at $1.255 million, while the total operating and start-up costs for the MacArthur II building are estimated at $1.050 million.

Needs Assessment. The proposed needs study, which is crucial to determining the future direction of the Home, is to identify the future health care needs of Indiana's veteran population, which totaled 592,673 in 1996. However, no specific target date for beginning or completing the study has been established. However, the Superintendent believes the needs study could be completed by the end of CY98. The study must be completed in time for it to be considered by the General Assembly for deliberations on the 1999-2001 Biennial Budget in September 1998, and continuing through the 1999 legislative session.

The purpose of the study is to provide better data for the Superintendent, his staff, and members of the Indiana General Assembly. The Superintendent has assumed that the needed critical demographic and health data for the study are currently available from other studies performed by the Veterans' Administration, the Indiana Association of Homes and Services for the Aging, the State Department of Health, Indiana University, Regenstrief Clinic, and other local sources.

The needs study group is to include representatives from the Governor's office, the State Department of Veterans' Affairs, the State Department of Health, the United States Veterans' Administration, the state Association of Homes and Services for the Aging, the IVH Governor's Advisory Committee, major veterans' organization leaders, IVH officials, and others to be determined. However, specific representatives of the needs study group have not been named. The study group needs to begin deliberations in April 1998 even if the study structure and procedures are not fully determined. The Superintendent believes that the study group can meet the data collection and review needs in a relatively short period of time. The Superintendent will recommend to the State Department of Health that the study group have an outside consultant from the long-term care industry to facilitate and assist the working group. The Superintendent does not believe that an outside contract to conduct the study is necessary. Whatever the final composition of the study group might be, it is imperative that the group be formed and begin its data collection and analysis. Even preliminary findings as to the future health needs of Indiana's Veteran population can help policy makers decide on the level of resources to allocate to the Home.

Statutory Issues. The General Assembly may

wish to review certain statutory requirements that impact the operation of the Indiana Veterans' Home. It is unclear if the current admissions policy to the Home by itself has an impact on the number of applicants who apply, or if the policy in concert with other factors affect the number who apply. The Home admission policy has a five-year residency requirement immediately preceding application. The policy also requires the veteran to have served one day with the United States military in any of its wars. A review of the residency requirements of the approximately 93 other state veterans' homes described in the annual report of the National Association of State Veterans' Homes (National Association of State Veterans' Homes, 1998) reveals that Indiana has one of the most restrictive residency requirements, with the possible exception of Wisconsin and Ohio. Several state veterans' homes have three-year residency requirements, but for the most part, most states require the applicant to be a resident of the state when applying for admission to the veterans' home. While Indiana requires service with the United States military in any of its wars, many state veterans' homes have no such requirement.

While the Home cannot provide specific data on the numbers of applicants to the Home who decide not to apply because of the admissions policy, staff members have provided anecdotal evidence that the policy has dissuaded some from applying because of the five-year requirement. For example, the Community Services Director described an Indiana veteran who went to school in Indiana, worked and paid taxes in Indiana, retired in Indiana, but eventually moved to Florida. After a few years, the veteran's health deteriorated and the family wanted to return to Indiana and have the veteran placed in the Home. However, because of the five-year residency requirement, they were unable to do so. The Community Services Director commented that there is no way of telling how many families do not consider application to the Home when they learn of the five year residency requirements.

While waivers to the residency requirement do happen, waivers are not guaranteed. Since August 1995, the Home has granted six waivers. During the same period, the Home has disapproved three waivers, with one waiver pending.

With the decline in the number of residents at the Home, the General Assembly may wish to review the admissions policy to determine what policy would best fit the needs of the Home for the future, taking into account the potential need for additional staff and the long-term goals of the Home as established by the needs study. The needs study may go a long way toward providing the answer.

County Appropriations. IC 10-6-1-6 authorizes the board of county commissioners in each county to make appropriations from the county general fund for the purpose of building a cottage or other needed buildings upon the grounds of the Home. Counties have not made appropriations since the 1980s, and the cottages and other buildings that were erected from these initial appropriations have been torn down. The statutory language appears to be outdated.

Indiana Department of Veterans' Affairs

Overview of the Indiana Department of Veterans' Affairs

Chapter 122 of Acts 1945 established the Indiana Department of Veterans' Affairs (IDVA). The IDVA was given "full authority to aid and assist veterans of the armed forces of the United States entitled to benefits or advantages provided on or after March 3, 1945, by the United States, the state of Indiana, or any other state or government." (IC 10-5-1-1).

IDVA Staff. The IDVA consists of nine employees: a director, a deputy director, a secretary to the director, two service officers, and a secretary to the service officer unit.[1] The Department also houses the State Approving Agency (SAA) which approves, monitors, and supervises educational and training programs for veterans and eligible individuals that have GI Bill educational benefits. The SAA consists of two program coordinators and a secretary. The IDVA is also responsible for the construction and operation of the Indiana Veterans' Memorial Cemetery located in Madison. The Department intends to hire a director, a secretary, and a head grounds keeper once construction begins in early 1999. (These positions are not shown in the organizational chart on page 4 of this report because as of April 1998, the State Personnel Department had not received a request for the anticipated positions.)

In addition to state officers, 90 county service officers serve veterans within their jurisdictions. IDVA and the county service officers help veterans apply for the various benefits that federal, state, and local governments offer to veterans. Benefits include burial allowances, burial in a state veterans' cemetery, recording of discharge papers, remission of fees at a state-assisted college or university for the children of disabled veterans, veterans' preference for state employment, various veterans' license plates, property tax deductions, free peddler's licenses, and admission to the Indiana Soldiers' and Sailors' Children's Home for relatives of veterans. The Department certifies a veteran's eligibility for many of these programs. Through its SAA, the IDVA also assists veterans in securing federal benefits, including education and training.

IDVA Budget. In FY96, IDVA spent $375,351. Of that amount, 321,133 (85.6%) was spent on personal services. The Department requested an operating budget of $744,497 in FY98 and $522,856 in FY99. The large increase in the FY98 budget request was due to the inclusion of a request to purchase equipment to build the Indiana State Veterans' Cemetery. The agency's appropriation, however, was set at $482,793 for FY98 and $583,424 for FY99. Exhibit 17 illustrates the breakdown of these appropriations.

In addition to these appropriations and as part of the Department's budget, IDVA controls a $10,000 annual appropriation in both FY98 and FY99 for the Combat Veterans' Consortium. Although outside the IDVA budget, the Disabled American Veterans (DAV) were appropriated $40,000; the Veterans of World War II, Korea, and Viet Nam (AMVETS) were appropriated $30,000; and the Veterans of Foreign Wars (VFW) were appropriated $30,000 in each of the two fiscal years. These appropriations are for the purpose of funding service officers and are listed as line items in the state budget.

Exhibit 17. Indiana Department of Veterans' Affairs: Expenditures and Appropriations, FY95-FY99.

Type	FY95		FY96		FY97		FY98		FY99	
	Expend	%	Expend	%	Expend	%	Approp'n	%	Approp'n	%
Pers'l Services	235,093	85.8%	269,266	83.4%	321,133	85.6%	* 360,218	76.2%	384,096	67.0%
Equip't	1,499	0.5%	8,634	2.7%	14,573	3.9%	55,150	11.6%	117,370	20.5%
Grants	1,016	0.4%	870	0.3%	850	0.2%	850	0.2%	850	0.1%
Other	36,294	13.3%	44,118	13.6%	38,795	10.3%	56,575	12.0%	71,108	12.4%
Total	**273,902**	**100.0%**	**322,888**	**100.0%**	**375,351**	**100.0%**	**472,793**	**100.0%**	**573,424**	**100.0%**

* Personal services include wages, salaries, fringe benefits, and other personal services. The FY98 wages and salaries appropriation was $259,686.

Veterans' Affairs Commission.

Chapter 122 of the Acts of 1945 established the Veterans' Affairs Commission to supervise and control the IDVA (IC 10-5-1-6). The Governor appoints the four members of the bi-partisan Commission to four-year terms. Membership is limited to honorably discharged veterans with at least six months of service. Veterans' organizations may not be represented by more than one member each. As of April 1998, members of the Commission represent the American Legion, Veterans of Foreign Wars, Disabled American Veterans, and AMVETS. The IDVA's director is the secretary of the Commission, but is not a voting member. The Chair of the Commission is elected from among Commission members.

The Veterans' Affairs Commission meets quarterly. Its specific duties are to promulgate rules and regulations for the administration of veterans' affairs statutes; to advise the veterans' State Service Officers on issues pertaining to the welfare of veterans; and to determine the general administrative policies within the IDVA. (State Service Officers serve as an interface between the veteran and his family members and any agency or organization needed to provide information, benefits, or counseling.)

A review of the Commission's minutes from its 1996 and 1997 meetings indicate that the Commission has met its statutory mandate. The following is a list of topics discussed by the Commission (** indicates official action taken).

IDVA Administrative Oversight

- Employee hiring
- Budget matters (fund balances, automobile purchases, computer purchases, federal funding of SAA Division, SAA Division pay scale, payments to veterans' organizations, staff reductions)
- IDVA computer user policy
- Annual training conference for county service officers **

Indiana Veterans' Memorial Cemetery at Madison

- Official name
- Transfer of property
- Federal funding and state funding
- Staffing level **
- Annual budget
- Master plan
- Site preparation
- Construction
- Historic preservation
- Residency requirements **
- Charge for spouses and out-of-state veterans
- Construction assistance from the National Guard
- Grounds keeping assistance from Madison State Hospital

War Memorials

- Fund raising, building , and dedication of the Viet Nam, Korean, and World War II War memorials
- Funding for a Women Veterans' Memorial in Washington, D.C.
- Memorial highway designations
- Local war memorial dedications

Legislation

- Reports from meetings of the Commission on Military and Veterans' Affairs
- Clarification of time limit for remission of fees for children of disabled veterans **
- State accreditation for county service officers **
- Admission of non-veteran-related children to the Indiana Soldier and Sailors Children's Home
- Enforcement of handicapped parking laws by trained civilians
- Burial and marker setting allowances for veterans
- Expand tax deduction authority to include IDVA

Veterans' Organizations

- Meetings and events staged at various veterans' facilities
- Resolutions from the groups regarding services and legislative matters
- Discussions on new groups **
- Bingo and electronic gambling

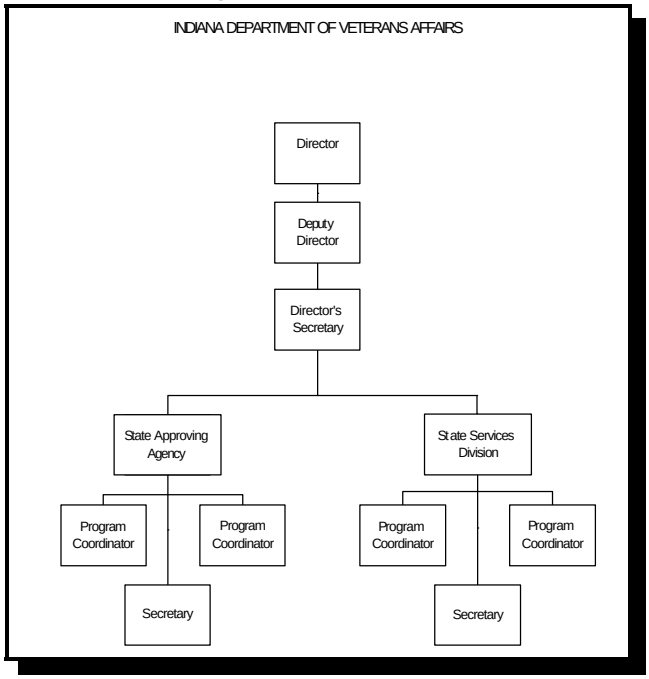
Other

- Denial of remission of fees benefits to child of a veteran whose discharge papers were allegedly altered
- Establishment of a marketing program in conjunction with the Lieutenant Governor
- VA hospitals
- VA Regional Office
- Veterans' outreach programs to inform veterans of their available benefits
- Conditions and building projects at Marion and Ft. Wayne VA hospitals

Indiana Department of Veterans' Affairs Personnel Issues

Two personnel issues face the IDVA. The first is that a conversion from non-merit to merit status might result in a more stable agency and staff. Second, reclassification of several staff positions may help to reverse the high turnover rate experienced by the agency in the past several years.[2] The IDVA organizational chart is depicted in Exhibit 18.

Exhibit 18. IDVA Organization Chart.



Non-merit to Merit Conversion. Merit agencies are subject to the State Personnel Act (IC 4-15-2) and are listed under IC 4-15-2-3.8. Many agencies are non-merit, such as the Department of Revenue, the Department of Natural Resources, the Department of Transportation, the Budget Agency, and central office staff of the Bureau of Motor Vehicles. [3] The IDVA was established as a non-merit agency and has never been converted to merit status.

Either the Governor, by executive order, or the General Assembly, through legislation, may convert an agency's status from non-merit to merit. Executive orders issued for this purpose occurred during Governor Matthew Welsh's tenure in the early 1960s.[4]

When an agency's employees are non-merit, not part of the union settlement, and do not have a unique statutory provision conferring due process rights, then under common law, they are considered "at will" employees. Two IDVA secretaries are part of the Unity Team union settlement.[5] The remaining seven have "at will" status. "At-will" employment means that absent an express agreement, or statutory authority, either the employee or the employer can terminate employment at any time, for any reason (which does not contravene public policy), with or without, cause.[6]

Effects of Conversion. A conversion to merit status could affect the IDVA's employees positively. It may provide more security and stability because their employment with the agency would not be contingent on the decision of each new director. Another benefit of converting to merit status could be realized by the agency as a whole if it enhances its stability and consistency. The continued presence of experienced staff could assist incoming directors learn the operations and functions of the agency, and its institutional history could be better preserved. Exhibit 19 illustrates the extent of turnover at IDVA over the past ten years.[7]

Exhibit 19. Staff Turnover at IDVA, 1988-98.

Time Period	Position Turnover *
8/88-1/89	3 out of 12
1/89-2/90	11 out of 12
2/90-4/91	3 out of 12
4/91-12/91	7 out of 12
12/91-2/93	7 out of 11
2/93-2/94	2 out of 10
2/94-9/95	4 out of 10
9/95-5/96	0 out of 10
5/96-2/97	3 out of 9
2/97-2/98	3 out of 9

* Turnover represents position changes between the beginning of the time period to the end of the time period and second date. Therefore, the turnover figure would represent a minimum for that time period.

However, potentially negative consequences of such a conversion include more bureaucratic hiring and separation procedures and less flexibility for the director. The agency's hiring practices would be affected by a conversion to a merit system. State merit employment is governed by the Personnel Act, IC 4-15-2, which establishes an employment system based on merit and objective factors relating to the appointment, compensation, promotion, transfer, lay off, removal, and discipline of employees. Employees must be selected from a list of candidates established by a ranking of test scores or other objective criteria. The merit system requires more administration and record-keeping than the non-merit system. In addition, some argue that non-merit employees are less entrenched and, therefore, more responsive to the direction of supervisors.

Reclassification of SAA Employees

High Turnover Rate Within the SAA Unit of the IDVA.

The IDVA reports a high turnover rate within the SAA unit. As of April 1998, the SAA unit consisted of two program coordinators and one secretary. (The IDVA Deputy Director acts as the SAA Director.) The IDVA reports a 75% turnover rate within the SAA unit in the last six months, and attributes their inability to retain SAA employees to low salaries.

Salaries of SAA Staff.

Because the three current SAA staff members have been in their current positions for less than a year, they are at the low end of the pay ranges corresponding to their job classifications.[8] The salaries of the two coordinators are $23,608 and $24,065; the secretary's salary is $15,351.[9] A survey conducted by the IDVA illustrates the disparities between the income and tenure of Indiana SAA staff and those of surrounding states (see Exhibit 20).[10]

The higher salaries in surrounding states may be due to tenure in the job and higher job classifications. As Exhibit 20 illustrates, Indiana's minimum entry-level salaries for SAA employees are considerably less than the other states surveyed.

History of the State Approving Agency.

The State Approving Agency (SAA) is a federal program established by Congress in 1947 to facilitate the provision of GI Bill benefits to veterans and other eligible individuals. Sixty-one SAAs exist nationally with two in Indiana. One SAA, located at the Indiana Commission on Proprietary Education, certifies private institutions of higher learning that provide both college and non-college degrees (IHL/NCD programs). The second SAA, at the IDVA, certifies public school, apprenticeships**,** and on-the-job training programs (APP/OJT programs). These programs include most hospital-based programs, cosmetology and barber schools, flight school training, law enforcement and firefighting academies, and Emergency Medical Services programs.[11]

Functions and Accomplishments.

In addition to approving educational programs, the SAA at the IDVA has conducted an outreach effort to seek out and certify as many facilities and programs as possible in order to provide GI Bill eligible veterans with a wider array of educational opportunities. In 1994, 38 active APP/OJT existed with 60 active IHL/NCD programs. As of April 1998, approximately 110 active APP/OJT programs existed (a 189% increase) with 100 active IHL/NCD programs (a 67% increase). As a result of the SAA outreach, the number of approved programs from which veterans may choose has dramatically increased, and individuals eligible for GI Bill benefits can more readily access the educational programming available to them. The Regional Office of the federal Department of Veterans' Affairs and the IDVA estimate that in Indiana, approximately 4,000 veterans and other eligible individuals receive approximately $9 million in GI Bill educational benefits.[12]

The three-member SAA unit approves new programs, ensures that programs operate as approved, conducts supervisory visits to active programs each year, investigates complaints made by eligible veterans, maintains files on inactive programs, and provides technical assistance and customer service to veterans and educational facilities. An active program is one in which at least one veteran or other eligible individual is enrolled and receiving GI Bill benefits. An approved program is one which the IDVA has determined meets the federal requirements for GI Bill-eligible individuals, but does not yet have such an individual enrolled. Consequently, all active programs are approved, but not all approved programs are active.

Exhibit 20. SAA Entry Level Salaries and Tenure in Indiana and Surrounding States as of April 1998.

State	IHL/NCD Salary*	IHL/NCD Tenure*	APP/OJT Salary**	APP/OJT Tenure**	Secretary's Salary	Secretary's Tenure	# of Active Programs	
							IHL/NCD	APP/OJT
Michigan	$45,000	10-15 yrs	$45,000	10-12 yrs	$19,000	19 yrs	129	25
Ohio	$37,600	5.5 yrs	$37,600	5.5 yrs	$21,000	7 yrs	280	107
Illinois	$35,304	6 yrs	$28,476	vacant	$24,864	30 yrs	420	90
Kentucky	$32,000	4 yrs	$32,000	4 yrs	$17,124	1 yr	133	35
Indiana	$23,608	< 1 yr	$23,608	< 1 yr	$15,351	< 1 yr	100	110

* IHL/NCD - Institutions of Higher Learning/Non-College Degree.
** APP/OJT - Apprenticeship/On-the-Job Training.

Upgrading Existing Staff. The IDVA Director intends to pursue upgrades for the two SAA service officers and the Deputy Director who serves as the SAA director. Because the state pay plan does not allow agency heads to grant individual pay raises, increases in salaries have to come as a result of promotion, the implementation of a unique pay plan for the agency, general salary adjustments, or by reclassification.

Promotion is not feasible because no vacancies exist within the agency at higher levels of employment. The only two positions above the service officers and the SAA staff are political appointments (the Director and Deputy Director).

The implementation of a separate pay plan can be established by statute or executive action. Public Law 91-1998 provided salary differentials to equalize the average salaries of the Department of Insurance with average salaries in other states. Public Law 70-1996 required the director of the State Personnel Department to conduct a survey of salaries paid to Department of Natural Resources professionals in nine other Midwestern states and to prepare a classification system and salary schedule for the professional employees of the Department of Natural Resources by June 30, 1998.

In order to pursue reclassification, the Director must submit a formal proposal to the State Personnel Department. The Department submitted such a proposal on April 9, 1998.

Of the options outlined above, the most workable seems to be a reclassification proposal. However, before a reclassification proposal can be considered, the agency must have enough money in the salary and wages category of its budget.

In anticipation of the reclassification proposal, the status of the SAA staff member classified as an Administrative Assistant 3 (PAT 3) on the manning table should be clarified. If this employee is performing the same duties as the other PAT 3 SAA employee, who is classified as a Program Coordinator 3, his or her classification should reflect that fact.

In addition, an inquiry into the proper classification of the Deputy Director/SAA Director as a PAT 2 may be warranted. It is unusual for a deputy director to have a PAT classification, rather than an ESM classification, particularly in light of the depth and breadth of the IDVA's Deputy Director's job responsibilities. However, it is also uncommon for a deputy director to supervise only six employees. The Personnel Department will review any position's classification upon request.[13]

In the IDVA's FY98 budget, $259,686 was appropriated for wages and salaries. Personnel expenses equaled $255,840. The difference of $3,846

represents the extra money the agency can use to fund reclassifications in FY98.[14] (The total amount budgeted for personal services is $360,218 and includes $259,686 for salaries and wages, $91,932 for fringe benefits, and $8,600 for other personal services.)

The IDVA may be able to reallocate funds between budget points.[15] To illustrate, during the first three quarters of the 1997-1998 budget, only $6,366 was dispersed from the $43,893 allotment for equipment. The remainder, or $37,527, could be used for salaries if the State Budget Director approved the reallocation. However, because salaries and wages are on-going expenses and equipment expenses are not, this request may not be feasible.

The Role of Federal Reimbursement. All SAAs contract with the federal government to approve, monitor**,** and supervise educational and/or training programs for individuals entitled to GI Bill benefits. The federal government expends $13 million nationwide to administer SAA programs. Indiana is reimbursed 100% by the federal government for salary, travel, and administrative expenses of the SAA.

The amount of the federal contract is determined by the number of active programs. As a result of the SAA's outreach efforts, the federal government has increased the SAA budget by 236% over the past four fiscal years.[16] The total SAA budget for FY98 was $132,781.[17] Due to the increase in programs and**,** consequently, federal dollars, the IDVA was able to hire an additional SAA program coordinator in November of 1995.

Despite the continued increase in federal dollars, the IDVA has been unable to use all of the federal funds allocated for salary and other expenses.[18] Any funds not used reverts to the federal government (Exhibit 21). This money could be used to help fund the SAA reclassifications, but because the contract is on a reimbursement basis, the federal funds cannot be used unless the State spends the money first. The Budget Agency and the State Personnel Department can not approve a reclassification if the money in the IDVA's budget is insufficient to fund the reclassification.

The circular nature of the situation puts the IDVA in a difficult position. The federal government contracts to reimburse the State at a level sufficient to fund several reclassifications, yet because the State cannot consider a reclassification without adequate funding in the IDVA budget up front, all unspent money originally contracted reverts to the federal Department of Veterans' Affairs, which in turn, may allocate these funds to another state's SAA unit.

Exhibit 21. Federal SAA Contracts and Reversions.

Fiscal Year	Total Contract	Amount Spent	Amount Reverted
FY94	$56,345	$41,323	$15,022
FY95	80,650	77,952	2,698
FY96	106,170	103,076	3,094
FY97	122,516	115,102	7,414
FY98	132,781	N/A	N/A

N/A - Not Available

Veterans' Affairs County Service Officers

History of County Service Officers. Acts 1945, c. 122, s. 11 established County Service Officers (CSO) to assist the IDVA in obtaining federal and state-funded benefits for eligible veterans. IC 10-5-1-11(a) provides that the county executive of each county is required to designate a CSO to render services to the veterans in the county. However, a county is not required to employ a CSO. If a CSO is designated and employed by a county, then the CSO is paid by the county. Ninety-one counties are meeting the statutory requirement of designating a CSO to serve Indiana's veterans. Marion County has chosen to designate the veteran service officer of various veterans service organizations, such as the American Legion, VFW, and AMVETS, to serve as the Marion County CSO.

IC 10-5-1-11(c)(2) provides that a CSO serves under the supervision of the IDVA Director.

Suggested Duties of County Service Officers. A CSO is responsible for informing veterans of and assisting veterans with federal and state-funded benefits. The CSO completes and submits the necessary benefit claim forms for a veteran.

According to the IDVA, the duties of a CSO are to:

- Collect and disseminate information regarding state and federal veterans' benefits.
- Assist veterans, their dependents and/or survivors in obtaining benefits by providing information and assistance.
- Assist clients by acquiring the appropriate forms and required documents and, if necessary, provide assistance for completion.
- Gather information and specific data on a case by case basis.
- Research to determine applicable laws, eligibility, and claim status.
- Maintain files on individual claimant and assistance provided.
- Attend CSO meetings and training seminars as designated by the IDVA.
- Represent veterans concerns to city/county agencies as needed.
- Provide the IDVA with appropriate reports, statistics, and other information as requested.
- Provide technical assistance to local government agencies.
- Assist veterans organizations, schools, and other organizations or groups at the local level as requested.
- Maintain up-to-date resource materials.
- Perform other duties as assigned.

Forty-four states have power of attorney to present federal benefit claims for veterans before the U.S. Department of Veterans' Affairs.[19] In Indiana, the IDVA and the CSOs cannot act as power of attorney for a veteran for federal benefit claims.[20] Instead, a veteran service organization recognized by the federal Department of Veterans' Affairs serves as a power of attorney for Indiana's veterans. The CSO forwards completed benefit claim forms to the veteran service organization that has power of attorney for the veteran. The IDVA Director may act as a power of attorney for a veteran with regard to state-funded benefits**,** but a CSO is not permitted to serve in such a capacity.[21]

The IDVA requests that CSOs submit monthly status reports that detail CSO activities, such as interviews, in-coming and out-going telephone calls, miles driven in support operations, claims, and attendance at veteran service organization meetings. The IDVA reports that 10% (9) of the CSOs do not submit monthly status reports.

CSO Qualifications and Training. A CSO is either an honorably discharged veteran who has had at least six months of active service in the armed forces of the United States and is a citizen of the United States and Indiana, or a spouse, surviving spouse, parent, or child of an eligible veteran.[22] A CSO is required to undergo training, as prescribed by the IDVA Commission, that includes familiarization with state and federal laws, rules, and regulations.[23] According to the IDVA, the training provided by the IDVA covers both federal and state-funded benefits equally.

A CSO must successfully pass a written examination before the IDVA certifies him or her as a qualified appointment.[24] The written examination is an open book/open note examination but it does not measure or ensure job-related competence. Passage of the written examination certifies, from the IDVA, that a CSO is qualified to serve in the appointed office. A

CSO that fails the written examination is not certified to serve in the appointment. Currently, there are 2 CSOs who are not certified to serve as a CSO in accordance with IC 10-5-1-12.

Salary and Office-Related Costs of a County Service Officer. The salary of a CSO as well as office assistance, space, equipment, and supplies are paid by the county. Exhibit 22 lists by county the CSO's salary and staff support and office-related expenses. Office hours for each CSO as well as the veteran population for each county are also provided.[25]

The salary of a CSO is determined by the county fiscal body. Salaries paid to CSO's ranged from no salary in Owen County to $26,313 in Elkhart County. Of the 91 CSOs, 36 had support staff costs. Vanderburgh County had the highest support staff cost at $42,644. In addition to CSO salary and support staff costs, office expenses ranged from no cost to $47,401 in Tippecanoe County.

Office hours for a CSO varied by county. Some office hours were by appointment only, and some CSO offices had regular business hours of up to 40 hours per week. Additionally, some offices are located in county courthouses or within the business district of a city or town. Other offices are located within a veteran service organization or the CSO's personal residence.[26]

Discharge of a County Service Officer. 915 IAC 1-1-7 provides that if in the judgement of the IDVA Commission, a CSO has violated any of the rules adopted by the Commission, or otherwise disqualified him or herself, or in the judgement of the Commission is unfit to perform the duties of the office or employment, the Commission may recommend to the county executive that the individual be discharged from office. The ultimate decision for the dismissal of a CSO lies with the county executive body. The IDVA does not have an example(s) of when a CSO was dismissed because of a recommendation of dismissal by the IDVA Commission.

Exhibit 22. County Service Officer Salaries, Expenses, Office Hours, and Veteran Population by County.

County	Service Officer Salary	Support Staff Costs	Office Expenses	Total	Per Veteran CSO Expenses	Weekly Hours	1996 Veteran Population
Adams	$3,174	$0	$1,950	$5,124	$2.22	By Appt.	2,310
Allen	$23,500	$0	$0	$23,500	$0.76	40	31,098
Bartholomew	$600	$20,352	$0	$20,952	$2.84	40	7,380
Benton	$3,450	$0	$3,650	$7,100	$7.49	35	948
Blackford	$10,355	$0	$700	$11,055	$7.00	15	1,580
Boone	$9,750	$0	$1,025	$10,775	$2.57	12	4,193
Brown	$17,000	$0	$1,585	$18,585	$9.88	30	1,881
Carroll	$19,512	$13,300	$2,085	$34,897	$19.34	36	1,804
Cass	$19,000	$0	$26,900	$45,900	$10.62	35	4,323
Clark	$7,264	$2,235	$820	$10,319	$0.92	22.5	11,195
Clay	$8,260	$0	$2,280	$10,540	$3.90	24	2,705
Clinton	$8,242	$0	$3,225	$11,467	$3.74	19.5	3,068
Crawford	$4,200	$0	$500	$4,700	$3.90	36	1,204
Davies	$11,788	$0	$1,690	$13,478	$4.82	24	2,795
Dearborn	$19,819	$0	$1,474	$21,293	$4.60	35	4,632
Decatur	$4,800	$0	$2,045	$6,845	$2.80	13.5	2,444
Dekalb	$17,382	$0	$1,750	$19,132	$5.38	32.5	3,558
Delaware	$18,918	$16,495	$4,100	$39,513	$3.27	40	12,096
Dubois	$12,000	$0	$2,800	$14,800	$4.40	22.5	3,362
Elkhart	$26,313	$35,707	$15,497	$77,517	$5.36	40	14,458

County	Service Officer Salary	Support Staff Costs	Office Expenses	Total	Per Veteran CSO Expenses	Weekly Hours	1996 Veteran Population
Fayette	$8,731	$6,635	$660	$16,026	$5.53	24	2,900
Floyd	$22,083	$0	$1,500	$23,583	$3.25	40	7,251
Fountain	$5,600	$0	$4,725	$10,325	$4.82	20	2,143
Franklin	$7,200	$0	$1,111	$8,311	$4.50	11	1,848
Fulton	$10,250	$7/hr	$1,810	$12,060	$5.26	28	2,294
Gibson	$21,093	$0	$2,324	$23,417	$6.51	40	3,596
Grant	$20,154	$15,393	$1,500	$37,047	$4.07	40	9,097
Greene	$19,775	$35,436	$8,525	$63,736	$15.40	35	4,139
Hamilton	$11,194	$18,350	$1,125	$30,669	$2.47	35	12,428
Hancock	$8,181	$3,209	$375	$11,765	$2.21	35	5,321
Harrison	$19,400	$0	$2,675	$22,075	$6.52	40	3,386
Hendricks	$11,032	$0	$480	$11,512	$1.29	18	8,938
Henry	$18,983	$14,542	$1,350	$34,875	$6.21	40	5,620
Howard	$22,600	$19,609	$2,145	$44,354	$4.62	40	9,597
Huntington	$22,880	$15,989	$5,255	$44,124	$13.04	40	3,383
Jackson	$16,599	$0	$21,624	$38,223	$9.39	35	4,069
Jasper	$13,200	$5,874	$1,000	$20,074	$8.22	40	2,442
Jay	$7,186	$0	$1,995	$9,181	$4.29	18	2,141
Jefferson	$9,416	$0	$6,573	$15,989	$4.44	8+Appt.	3,604
Jennings	$4,000	$0	$2,660	$6,660	$2.58	21	2,583
Johnson	$23,344	$2,306	$3,087	$28,737	$2.96	40	9,711
Knox	$13,400	$12,510	$1,150	$27,060	$6.32	35	4,285
Kosciusko	$9,768	$0	$1,350	$11,118	$1.68	20	6,619
Lagrange	$3,822	$0	$1,275	$5,097	$2.70	By Appt.	1,885
Lake	$22,630	$12,649	$1,797	$37,076	$0.75	40	49,262
LaPorte	N/A	N/A	N/A	N/A	$0.00	N/A	13,372
Lawrence	$10,542	$3,360	$1,125	$15,027	$2.93	14	5,121
Madison	$19,897	$17,810	$2,395	$40,102	$2.72	40	14,729
Marion				$0			83,115
Marshall	$7,228	$0	$1,055	$8,283	$1.89	15	4,388
Martin	$3,650	$0	$750	$4,400	$3.62	4	1,216
Miami	$15,700	$12,200	$5,411	$33,311	$8.63	40	3,862
Monroe	$10,371	$0	$1,046	$11,417	$1.23	40	9,278
Montgomery	$5,290	$1,838	$2,200	$9,328	$2.47	By Appt.	3,777
Morgan	$1,440	$0	$0	$1,440	$0.23	15	6,333
Newton	$6,525	$0	$2,120	$8,645	$6.20	21	1,395
Noble	$9,630	$0	$2,650	$12,280	$3.33	7	3,688
Ohio	$922	$0	$1,280	$2,202	$3.51	14	628
Orange	$5,564	$0	$1,090	$6,654	$3.31	5	2,013
Owen	$0	$0	$750	$750	$0.36	28	2,099
Parke	$12,000	$3,640	$3,150	$18,790	$9.49	35	1,981
Perry	$18,783	$6,643	$5,870	$31,296	$13.57	35	2,307

County	Service Officer Salary	Support Staff Costs	Office Expenses	Total	Per Veteran CSO Expenses	Weekly Hours	1996 Veteran Population
Pike	$8,200	$0	$1,350	$9,550	$6.75	14	1,414
Porter	$14,632	$0	$550	$15,182	$1.03	21	14,705
Posey	$5,741	$200	$845	$6,786	$2.40	4	2,829
Pulaski	$10,420	$7,949	$1,600	$19,969	$15.34	24	1,302
Putnam	$12,380	$0	$2,070	$14,450	$3.98	21	3,635
Randolph	$5,174	$0	$1,464	$6,638	$2.37	35	2,806
Ripley	$10,500	$0	$2,995	$13,495	$5.19	21	2,601
Rush	$10/hr	$0	$2,000	$2,000	$1.12	By Appt.	1,790
St. Joseph	$15,150	$0	$0	$15,150	$0.58	37.5	26,107
Scott	$18,147	$15,604	$11,667	$45,418	$22.03	35	2,062
Shelby	$3,000	$0	$2,000	$5,000	$1.17	4	4,283
Spencer	$16,768	$0	$3,500	$20,268	$9.28	35	2,185
Starke	$7,873	$300	$750	$8,923	$3.69	19.5	2,421
Steuben	$13,800	$0	$1,485	$15,285	$4.79	9	3,190
Sullivan	$15,060	$20,970	$7,850	$43,880	$20.13	40	2,180
Switzerland	$3,776	$0	$560	$4,336	$5.02	15	863
Tippecanoe	$21,152	$20,148	$47,401	$88,701	$7.72	40	11,487
Tipton	$12,240	$4,732	$5,000	$21,972	$12.43	24	1,768
Union	$4,276	$0	$500	$4,776	$8.15	By Appt.	586
Vanderburgh	$22,000	$42,644	$1,000	$65,644	$3.61	40	18,199
Vermillion	$10,000	$7,020	$2,300	$19,320	$10.05	20	1,922
Vigo	$1	$36,812	$1,170	$37,983	$3.20	40	11,874
Wabash	$9,100	$4,900	$2,475	$16,475	$5.17	20	3,187
Warren	$3,588	$0	$210	$3,798	$4.15	6	916
Warrick	$21,631	$18,284	$4,700	$44,615	$9.64	40	4,627
Washington	$2,900	$0	$8,800	$11,700	$4.56	32.5	2,567
Wayne	$10,609	$0	$2,942	$13,551	$1.66	20	8,142
Wells	$7,956	$0	$1,225	$9,181	$3.72	20	2,467
White	$12,094	$14,344	$3,020	$29,458	$11.50	21	2,561
Whitley	$4,000	$0	$2,390	$6,390	$2.05	30	3,119
Total	$1,027,558	$489,989	$306,858	$1,824,405	$3.08		592,673

Concerns Regarding County Service Officers. The IDVA Director, state service officers, and representatives from various veterans' organizations[27] identified the following concerns: (1) the IDVA's lack of effective authority over the CSOs and the lack of accountability that CSOs have to the IDVA; and (2) the impact the CSOs have on the amount of federal benefits Indiana's veterans receive.

Lack of Effective Authority. A CSO is appointed by a county's executive body and is paid by the county while under the supervision of the IDVA Director. The IDVA Director, state service officers, and representatives from veteran service organizations indicate that CSOs are political appointees and are not accountable to anyone but the county executive body.

Despite the fact that IC 10-5-1-9 places a CSO under

the supervision of the IDVA Director, as a practical matter the county appoints a CSO and pays the salary and expenses of a CSO, and the IDVA lacks effective authority over a CSO. The IDVA reports that within the last five years, three instances where a county executive body ignored recommendations made by the IDVA Director to dismiss a CSO and the CSO remained in the appointment. Some counties believe that since the county appoints and pays the CSO the IDVA has no authority to make requirements of a CSO or to recommend disciplinary action or dismissal of a CSO.

Training and Certification. Mandatory training for CSOs is required by IC 10-5-1-12 as prescribed by the IDVA Commission. The IDVA provides training for CSOs to keep them informed of changes in rules governing federal and state benefits. Training consists of an annual three-day session at a specified location in the state. The IDVA Director revealed that many times CSOs do not attend the mandatory training. For example, in one county the CSO did not attend any required training sessions during the CSO's 16-year tenure. The IDVA estimates that approximately 8.8% of the CSOs did not attend the mandatory annual training in 1997 and 14.2% did not attend for 1996.[28]

Upon the completion of the mandatory training, a CSO takes a written examination. Successful passage of the written examination before the IDVA certifies a CSO as a qualified appointment. Failure to pass the written examination means the individual is an unqualified appointment. A makeup examination is offered and taken by those CSOs who do not attend the training session or fail to pass the examination.

The IDVA Director stated that a county is notified if the CSO does not attend the required training and successfully pass the written examination**,** but the IDVA Director is unable to take any further action.[29] Non-attendance at the mandatory training and failure to pass the written examination by a CSO means the individual is not certified and is not in compliance with state law. Currently, there are 2 CSOs who are not in compliance with the statute.

A one day non-mandatory training session is given each year in the fall. Instead of having the session provided at one location, the fall session is usually split with a site in the north and one in the southern part of the state.

Impact on Benefits to Veterans. Indiana's veteran population of 592,673 represents approximately 2.3% of the total veteran population in the United States**,** ranking 15th out of all states and the District of Columbia. Indiana veterans receive only about 1.5% ($337,299,761) of the total veteran non-medical/non-capital expenditures. (This total would include compensation and pension, readjustment benefits and vocation rehabilitation, and insurance and indemnities.) While Indiana is 15th in terms of veteran population**,** it is 28th in non-medical/non-capital expenditures and 48th in per capita non-medical/non-capital expenditures ($569.12).

In comparison, Louisiana has 214,530 fewer veterans than Indiana but receives approximately $64 million more in non-medical/non-capital benefits than Indiana receives--receiving $1,062 per capita and ranking 10th. Appendix 2 illustrates the geographic distribution of veteran's expenditures by state, including total and per capita expenditures.

Appendix 3 illustrates the geographic distribution of veteran's expenditures by Indiana's counties including total and per capita expenditures. Appendix 3 illustrates the wide variation by county in non-medical/non-capital benefits received by veterans in federal fiscal year 1996. Switzerland County ranks first in per capita non-medical/non-capital expenditures at $1,188 per veteran. Porter County ranks 92nd per capita in non-medical/non-capital expenditures at $354 per veteran. Spencer County has the median per capita (46th ranking) non-medical/non-capital expenditures of $571.

Impact of Training on Benefits. A state service officer and representatives of veteran service organizations suggest that the lack of training of CSOs affects the amount of benefits Indiana's veterans receive from the federal government. The belief is that if a CSO is unaware of federal benefit regulations and eligibility, then the veteran is also unaware of the federal benefit regulations and eligibility. The result is that the veteran is not receiving the eligible federal benefits.

While the representatives of some veteran service organizations believe that the lack of CSO training affects the amount of benefits that veterans receive, the *Sunset Performance Audit of Human Services Program in Indiana* (December 1980) states that

IDVA training does not seem to affect the amount of benefits a veteran receives. When comparing the CSOs who missed two or more spring training sessions with those who had attended training, no significant difference was found in either the amount of veteran benefits received per veteran in the county or in the number of claims filed per veteran.[30]

The report also noted that while training for the appointed CSO on veterans benefits is needed, it can be derived through a variety of sources such as the federal Veterans' Administration, veteran service organizations, manuals, peer groups, or on-the-job training.[31] One CSO stated that while the IDVA training is good, it is duplicated by the American Legion, Red Cross, VFW, and other sources.[32]

One option for increasing attendance at annual training is to have training in regional areas rather than one specified location. Regional training would reduce travel time and expenses for CSOs.

The final report of the Indiana Commission on Military and Veterans' Affairs noted that one possible reason for Indiana's low receipt of benefits could be due to the federal regional disability ratings board at the federal Department of Veterans' Administration regional office in Indianapolis. The Indiana Ratings Board may not be rating Indiana veterans as high as other states rate veterans with comparable disabilities. For example, a shoulder disability in Indiana may receive a disability rating of 10% while in Louisiana that same disability may be rated at 30%. This could explain the variation in benefits among states but does not explain the variation among counties since all the counties are under the same regional ratings board. While this explanation is not related to the CSOs**,** it is an explanation worth noting.[33]

Impact of Salary and Support Staff Costs on Benefits. Conversations with a state service officer and representatives from veteran service organizations identified CSO salaries as a possible factor which influences the amount of veteran benefits received in each county. The belief is "you get what you pay for." Based on the salary information provided in Exhibit 22 and the per capita benefits received in each county (Appendix 3), there was no correlation between salary and per capita benefits. Additionally, there was no correlation between CSO salary, support staff costs, and per capita benefits.

Impact of Organizational Structure on Benefits. Exhibit 22 identifies the number of hours each CSO office is open per week. A small number of business hours could affect services to veterans which, in turn, could affect the amount of benefits a veteran receives. However, a correlation between CSO hours and veteran benefits did not exist. For example, Switzerland County had the highest per capita of non-medical/non-capital expenditures**,** but the CSO worked only 15 hours per week. Porter County had the lowest per capita non-medical/non-capital expenditures, and the CSO worked 21 hours per week. Spencer County had the median per capita non-medical/non-capital expenditures**,** and the CSO worked 35 hours per week. The CSOs in Union County and Montgomery County had office hours by appointment only. Union County ranked 8th per capita non-medica/non-capital expenditures**,** and Montgomery County ranked 90th per capita non-medical/non-capital expenditures. There was no correlation between the number of working hours and the amount of per capita benefits received.

Options for Organizational Structure. A telephone survey of seven states provided a number of different options that a state can use in organizing its structure of CSOs. Exhibit 23 lists the states, number of counties in each state, and each state's organizational structure with regard to CSOs. Oklahoma has an organizational structure similar to Indiana**,** but ranks first nationwide in per capita non-medical/non-capital expenditures. Ohio also has an organizational structure similar to Indiana's and ranks 43rd nationwide in per capita non-medical/non-capital expenditures. In Arkansas, each county has a service officer, but the county is reimbursed by the state. The amount of reimbursement depends on the veteran population. Arkansas is ranked 2nd in per capita non-medical/non-capital expenditures. Michigan, ranking 49th in per capita non-medical/non-capital expenditures, pays veteran service organizations to assist veterans with benefits. Illinois uses state employees to assist veterans and ranks 51st (out of the 50 states and the District of

Columbia) in per capita non-medical/non-capital benefits.

Each state has a different organizational structure with regard to CSOs. Some states have an organizational structure similar to Indiana's while other states place CSOs under state authority or provide state reimbursement to the county level. There appears to be no correlation between the type of organizational structure a state has and the amount of federally funded veteran benefits a state receives.

Exhibit 23. Organizational Structure of Various States

State*	Number of Counties	Organizational Structure
Oklahoma	88	Each county has a county service officer funded by the county.
Arkansas	75	Each county has a county service officer funded by the county. The State pays a county a maximum of $3,600 per year for a veteran population of less than 2,500 and a maximum of $4,800 for a veteran population of more than 2,500.
Mississippi	82	Each county may employ a county veteran service officer who is paid by the county.
Kentucky	120	Six regional coordinators are paid by the Commonwealth. The regional coordinators recruit and oversee volunteers who are responsible for implementing all veteran-benefit programs.
Ohio	88	Each county has a minimum of one county service officer funded by the county (more populated areas may have more than one county service officer).
Indiana	92	Each county shall designate and may employ a county service officer. Indiana has 91 county service officers paid by the appointing county.
Michigan	83	The State appropriated approximately $3.5 million in FY98 to pay service officers of veteran service organizations. Some county service officers are paid by the county.
Illinois	102	The State has 43 full-time state service officers paid by the state. There are 56 sites throughout the state. Illinois appropriated approximately $3.6 million in 1998. Illinois also has Veteran Assistance Commissions on the county level that are funded by counties and located in the more urban counties of the state.

* Order of states is by per capita ranking in federal benefits received.

Indiana could continue with the existing organizational structure, implement a structure identified in Exhibit 23, or implement an organizational structure different from the ones in Exhibit 23 and Indiana's existing structure. In addition to the organizational structures identified in Exhibit 23, Indiana could place CSOs partially under the state. This could be accomplished in the following

way. The county executive would nominate to the IDVA Commission three individuals for the position of CSO with the IDVA Commission making the final appointment. The cost of paying the CSO as well as the cost of support staff, office space, equipment, and supplies could be evenly shared between the state and the county. Based on information in Exhibit 22, the minimum cost to the state would be $912,202 with counties liable for the same amount. By placing the final CSO appointment under the IDVA Commission and with the state paying a portion of the salary and expenses**,** the state could hold the CSO accountable with regard to mandatory training and regular office hours. This type of organizational structure could allow the IDVA to have more effective authority over the CSOs.

A second possibility is to place CSOs completely under the state. The minimum cost to the state would be approximately $1.8 million per year. This cost could be reduced if regional CSOs were appointed to less populated areas. Placing the CSOs under the authority of the state could allow for the standardization of CSO competency, salaries, office location, and hours.

Conclusion. The IDVA and the CSOs were established to assist veterans in receiving federal- and state-funded veteran benefits. Ninety-one counties meet the statutory requirement of designating a CSO. Marion County has not designated a CSO and uses the service officer of various veteran service organizations as the county's CSO.

While Indiana's system does assist veterans**,** it is difficult to explain why Indiana ranks 48th per capita in federally funded veteran benefits. Based on conversations with the IDVA Director, a state service officer, and representatives of veteran service organizations, the belief is that one or a combination of factors, such as the amount of money paid by a county to a CSO, office location and hours, intensity of training affect the amount of federally funded benefits Indiana's veterans receive. However, there were no correlations discovered between the CSO salary, staff support costs, hours worked, and the per capita benefits.

Options for change include restructuring the existing system, but there was no correlation in the structure used in other states and the amount of per capita benefits received.

Another option is to have regional training to increase attendance. However, there appears to be no correlation between attendance at training and per capita benefits received.

At this time there is not a clear cut solution to increasing Indiana's per capita ranking in federal benefits.

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Appendices

Appendix 1. Alzheimer's Facility Options & Cost Analysis

Build New Facility or Reopen Second Floor On MacArthur
03/25/98

	New Building			MacArthur II		
	#	Cost	Total	#	Cost	Total
Startup Cost:						
Room Furniture						
Captain Beds With Drawers	32	$440	$14,080	0	$440	$ 0
Mattresses (36x8O) Deluxe	32	210	8,720	30	210	6,300
Nightstands With Draw	32	140	4,480	30	140	4,200
Chairs	32	309	9,888	0	309	0
Overbed Tables	32	159	5,088	30	159	4,770
Cubicle Curtains	32	85	2,720	0	85	0
Window Curtains	32	230	7,360	0	230	0
TV's	32	315	10,080	0	315	0
TV Remotes	32	55	1,760	30	55	1,650
TV Wall Mounts	32	120	3,840	0	120	0
Room Total:			$66,016			$16,900
Equipment:						
Medicine Carts (Metroflex)	2	$2,000	$4,000	2	$2,000	$4,000
Treatment Carts	1	1,600	1,600	1	1,600	1,600
Janitor Carts	2	310	620	0	310	0
Nurse Station Chairs	8	168	1,344	5	168	840
Patient Charts	32	14	448	1	14	0
Chart Rack	1	400	400	0	400	0
Chart Dividers	32	15	480	0	15	0
Set Of Reference Books	1	500	500	1	500	500
Linen Hampers	4	150	600	4	150	600
Linen Carts	3	300	900	3	300	900
Suction Machines (Portable)	2	300	600	2	300	600
Ear Thermometers	2	450	900	2	450	900
Pulse Oximeter	1	1,300	1,300	1	1,300	1,300
Hoyer Lift	1	5,195	5,195	0	5,195	0
Syringe Boxes	32	50	1,600	0	50	0
Glove Boxes	32	10	320	0	10	0
Gloves (Cases)	2	88	176	2	88	176
Scale	1	2,300	2,300	1	2,300	2,300
Linens (Sheets, Towels, Etc.)	1	6,000	6,000	1	6,000	8,000
Washable Underpads	128	11	1,408	120	11	1,320
Washable Briefs	128	14	1,792	120	14	1,680
Shower Chairs (PVC)	6	150	900	0	150	0
Side Entry Tubs	2	9,100	18,200	0	9,100	0
Ado Lift For Ado Tub	0	3,800	0	1	2,000	2,000
Shower Curtains	4	30	120	0	30	0
Soap Dispensers & Soap	1	100	100	1	100	100
Paper Towel Dispensers	50	36	1,800	0	36	0
Equipment Total:			$53,603			$24,816
Lounge Furniture:						
Couches	2	$540	$1,080	2	$540	$1,080
Chairs	8	480	3,680	4	460	1,840
End Tables	4	130	520	0	130	0
20" TV's	2	400	800	1	400	400

	New Building			MacArthur II		
	#	Cost	Total	#	Cost	Total
VCR's	2	$200	$400	0	$200	$0
VCR Wall Mounts	2	35	70	0	35	0
Lounge Total			$6,550			$3,320
Kitchen:						
Dinning Tables 42' Sq.	5	$190	$950	5	$190	$950
Chairs	20	130	2,600	20	130	2,600
Refrigerator	1	530	530	1	530	530
Ice Machine	1	2,500	2,500	0	2,500	0
Microwave	1	480	480	0	480	0
Water Mugs	64	3	193	60	3	180
Total:			$7,253			$4,260
Grand Total Startup Cost:			**$133,422**			**$49,296**
Operating Cost:						
Nursing:						
Nurse Supervisor 6	1	$43,049	$43,049	1	$43,049	$43,049
Clerical Assistant 5	1	18,017	18,017	1	18,017	18,017
Charge Nurse 3	1	42,569	42,569	1	42,569	42,569
RN4	1	38,065	38,065	1	38,065	38,065
LPN's	6.5	26,213	170,385	6.5	26,2l3	170,385
NA 4	1	20,195	20,195	1	20,195	20,195
NA 5's	17.5	18,386	321,755	15	18,386	275,790
Total Nursing:			$654,035			$608,070
Recreation:						
RTA3	1	$25,696	$25,696	1	$25,696	$25,696
Intermittent	1	13,578	13,578	1	13,578	13,578
Part Time	1	13,632	13,632	1	13,632	13,632
Total Recreation:			$52,906			$52,906
Laundry:	1	$26,980	$26,980	1	$26,980	$25,980
Housekeeping:	2	26,980	53,960	2	28,980	53,960
Social. Services:	1	36,920	36,920	1	36,920	36,920
Dietary:	2	19,346	38,692	2	19,346	38,692
Maintenance:	1	26,693	26,693	1	26,693	26,693
Total Other Departments:			$183,245			$183,245
Total Personnel Cost:			**$890,186**			**$844,221**
Expenses:						
Utilities	39,000	$2	$82,875	17,000	$1	$17,000
Training	29	34	986	26.5	34	901
Health Care: Agency	32	1,260	40,320	30	1,250	37,500
Hap-B Tests	29	18	522	26.5	18	477
Office Supplies	29	92	2,668	26.5	92	2,438
Food	29	1,500	43,500	26.5	1,500	39,750
Wearing Apparel	87	15	1,306	79.5	15	1,192

	New Building			MacArthur II		
	#	Cost	Total	#	Cost	Total
Drugs	32	$1,512	$48,384	30	$1,512	$45,360
Computers	7	1,500	10,500	7	1,500	10,500
Computer Furniture	7	150	1,050	7	150	1,050
Total Expenses			$232,111			$156,168
Grand Total Operating Cost:			**$1,122,297**			**$1,000,389**
Grand Total Startup & Operating Cost:			**$1,255,719**			**$1,049,685**

Assumptions: MacArthur II

1. Beds currently in place on floor are usable if modified with half rails and repaired as needed.
2. Chairs currently in place on floor are usable if repaired by maintenance to comply with code.
3. TVS currently in place on floor are adequate if in working order and not used elsewhere.

Appendix 2. Geographic Distribution of VA Expenditures for FFY96 (Summary of Expenditures by State).

State or Territory	Veteran Population	Rank	Total Expenditures	Total Non-Medical Non-Capital Expenditures	Rank	Per Capita	Rank **	Compensation and Pension	Rank	Per Capita	Rank	Readjustment Benefits and Vocational Rehabilitation	Insurance and Indemnities	Construction and Related Costs	Medical Services and Administrative Costs
United States	26,212,233		40,561,148,247					18,617,458,811				1,428,971,431	2,063,330,302	632,042,969	17,819,293,755
Oklahoma	349,700	28	726,678,665	518,469,080	14	1,482.61	1	463,643,901	11	1,325.80	1	31,509,111	23,316,068	11,174,043	197,034,204
Arkansas	258,171	32	628,680,450	371,737,484	24	1,439.89	2	338,746,860	21	1,312.10	2	15,075,587	17,915,037	7,149,204	249,792,427
Mississippi	233,380	33	547,312,447	306,025,281	30	1,311.27	3	277,296,846	28	1,188.18	3	13,535,449	15,192,986	8,927,122	232,358,825
Dist. of Columbia *	50,219	50	1,072,472,651	61,050,778	47	1,215.68	4	53,046,353	47	1,056.29	4	3,649,425	4,355,000	5,521,744	1,005,899,022
New Mexico	171,930	36	353,545,221	204,979,048	33	1,192.22	5	176,046,295	33	1,023.94	6	14,909,759	14,022,994	2,027,361	146,537,749
Maine	153,460	38	256,009,584	180,649,559	36	1,177.18	6	161,034,872	34	1,049.36	5	9,251,667	10,363,020	168,898	75,190,039
Alabama	427,048	22	812,262,006	497,200,068	16	1,164.27	7	435,508,143	15	1,019.81	7	33,416,866	28,275,059	8,915,423	306,145,473
South Dakota	74,034	46	207,715,479	83,183,808	45	1,123.59	8	67,714,444	45	914.64	11	9,325,363	6,144,001	3,252,249	121,278,451
West Virginia	199,350	34	458,785,961	217,362,241	31	1,090.35	9	195,513,928	31	980.76	8	10,618,326	11,229,987	6,531,003	234,891,697
Louisiana	378,140	25	701,722,970	401,609,240	20	1,062.06	10	349,290,206	20	923.71	9	27,191,131	25,127,903	235,701	299,877,076
North Carolina	710,690	10	1,121,771,742	742,059,690	7	1,044.14	11	643,246,430	7	905.10	12	50,813,356	47,999,904	4,283,893	375,427,235
Kentucky	367,200	27	620,528,924	380,865,060	22	1,037.21	12	338,224,217	22	921.09	10	22,366,825	20,274,018	4,804,411	234,858,500
Montana	95,402	44	149,540,756	98,381,772	44	1,031.23	13	81,805,803	43	857.48	16	8,405,994	8,169,975	3,249,067	47,909,001
Texas	1,646,770	3	2,884,427,212	1,678,392,685	2	1,019.20	14	1,446,185,796	2	878.20	13	115,017,136	117,189,753	85,303,209	1,120,730,425
Georgia	684,600	12	1,093,547,732	695,307,167	9	1,015.64	15	601,049,436	8	877.96	14	48,362,047	45,895,684	13,673,890	384,565,775
Virginia	704,650	11	1,076,555,794	707,150,227	8	1,003.55	16	587,999,036	9	834.46	19	59,718,317	59,432,874	3,229,896	366,174,809
South Carolina	379,720	24	583,611,093	381,031,888	21	1,003.45	17	324,944,986	23	855.75	17	29,203,876	26,883,026	3,039,913	199,538,396
Arizona	458,571	21	751,134,593	458,684,357	18	1,000.25	18	376,421,482	18	820.86	20	39,128,832	43,134,043	10,906,281	281,543,096
Tennessee	516,140	18	1,019,223,652	512,978,568	15	993.87	19	452,595,280	13	876.88	15	29,605,230	30,778,058	9,319,205	496,924,974
Alaska	64,923	47	118,742,164	64,027,583	46	986.20	20	54,870,698	46	845.16	18	6,413,879	2,743,006	2,140,883	52,572,789
Florida	1,709,060	2	2,544,360,508	1,634,468,236	3	956.36	21	1,364,182,838	3	798.21	21	90,702,785	179,582,613	19,803,041	890,088,409
Colorado	385,445	23	670,250,084	367,291,070	26	952.90	22	296,158,292	26	768.35	25	38,384,782	32,747,996	2,340,174	300,618,021
Nebraska	167,560	37	288,681,961	157,922,091	37	942.48	23	130,377,488	37	778.09	23	12,831,603	14,713,000	153,312	130,605,720
North Dakota	59,168	49	100,438,789	55,236,418	49	933.56	24	42,676,473	50	721.28	31	7,131,938	5,428,007	323,766	44,877,803
Wyoming	47,935	51	101,126,654	44,031,916	51	918.58	25	36,088,964	51	752.88	26	3,946,951	3,996,001	2,334,480	54,759,428
Rhode Island	109,140	43	178,510,713	99,401,175	43	910.77	26	85,726,024	41	785.47	22	4,821,151	8,854,000	2,495,261	76,613,429
Washington	630,580	13	886,002,297	573,184,289	10	908.98	27	470,268,112	10	745.77	27	57,357,221	45,558,956	9,962,035	302,855,190

Appendix 2. Geographic Distribution of VA Expenditures for FFY96 (Summary of Expenditures by State).

State or Territory	Veteran Population	Rank	Total Expenditures	Total Non-Medical Non-Capital Expenditures	Rank	Per Capita	Rank **	Compensation and Pension	Rank	Per Capita	Rank	Readjustment Benefits and Vocational Rehabilitation	Insurance and Indemnities	Construction and Related Costs	Medical Services and Administrative Costs
Hawaii	115,670	41	179,815,301	104,956,782	41	907.38	28	78,818,303	44	681.41	33	10,043,479	16,095,000	20,666,508	54,191,253
Massachusetts	593,980	14	1,101,960,162	538,376,242	12	906.39	29	457,674,929	12	770.52	24	23,321,387	57,379,926	8,628,427	554,954,686
Idaho	112,150	42	157,142,492	99,532,912	42	887.50	30	82,417,660	42	734.89	29	8,689,245	8,426,007	1,864,994	55,743,780
New Hampshire	135,340	40	170,576,652	118,888,473	39	878.44	31	100,918,667	39	745.67	28	7,352,794	10,617,012	44,844	51,642,522
Oregon	370,810	26	591,880,024	316,120,074	29	852.51	32	267,886,002	30	722.43	30	22,330,018	25,904,054	10,745,988	265,013,180
Vermont	62,257	48	111,679,284	51,143,411	50	821.49	33	43,572,782	49	699.88	32	2,860,634	4,709,995	1,073,928	59,461,164
Kansas	262,790	31	460,769,703	214,395,012	32	815.84	34	177,086,024	32	673.87	34	16,802,987	20,506,001	1,503,076	244,870,875
Utah	138,290	39	253,322,395	111,197,221	40	804.09	35	87,796,182	40	634.87	37	11,229,021	12,172,018	4,207,563	137,916,899
Nevada	186,070	35	254,196,894	146,136,330	38	785.38	36	122,734,764	38	659.62	35	10,435,566	12,966,000	670,189	107,389,642
Missouri	585,850	16	874,211,601	453,724,781	19	774.47	37	383,810,659	17	655.13	36	29,580,204	40,333,918	10,150,276	410,335,836
Minnesota	461,910	20	654,876,441	337,685,492	27	731.06	38	272,212,375	29	589.32	39	23,893,118	41,579,999	1,501,384	315,688,908
Wisconsin	507,390	19	689,102,761	367,941,415	25	725.16	39	301,187,529	25	593.60	38	23,526,843	43,227,043	4,595,515	316,565,174
Delaware	78,481	45	125,325,325	56,025,356	48	713.88	40	45,851,168	48	584.24	41	3,941,195	6,232,993	9,134,495	60,164,801
New York	1,537,770	4	2,417,919,963	1,095,781,771	4	712.58	41	905,854,690	4	589.07	40	46,082,937	143,844,144	22,324,347	1,299,813,212
Maryland	530,310	17	635,218,244	373,238,319	23	703.81	42	303,094,196	24	571.54	42	25,513,076	44,631,047	8,902,524	253,076,763
Iowa	291,130	30	403,587,285	196,710,251	34	675.68	43	157,872,561	35	542.28	45	14,195,568	24,642,122	3,683,462	203,192,950
Ohio	1,188,170	6	1,362,841,909	782,784,067	6	658.81	44	654,257,529	6	550.64	43	48,783,456	79,743,082	7,376,843	572,680,399
Pennsylvania	1,363,210	5	1,696,943,630	895,553,187	5	656.94	45	744,739,479	5	546.31	44	42,707,276	108,106,432	13,875,114	787,514,734
California	2,817,645	1	3,611,006,423	1,799,711,417	1	638.73	46	1,449,380,014	1	514.39	46	127,279,377	223,052,026	145,377,384	1,665,917,061
New Jersey	740,660	9	754,516,807	459,361,386	17	620.21	47	367,649,144	19	496.38	47	17,345,248	74,366,994	16,571,179	278,583,680
Indiana	**592,670**	**15**	**604,533,190**	**337,299,761**	**28**	**569.12**	**48**	**282,640,193**	**27**	**476.89**	**48**	**23,407,695**	**31,251,873**	**13,261,023**	**253,971,854**
Michigan	949,060	8	1,050,859,010	533,622,544	13	562.26	49	446,827,043	14	470.81	49	29,357,722	57,437,779	40,450,905	476,785,027
Connecticut	339,079	29	402,197,318	187,504,059	35	552.98	50	143,556,700	36	423.37	50	10,094,323	33,853,036	25,972,391	188,720,359
Illinois	1,073,560	7	1,384,318,358	561,825,407	11	523.33	51	424,180,725	16	395.12	51	48,688,562	88,956,120	22,431,188	800,061,301
Guam	7,818		6,797,967	6,797,119		869.42		6,628,239		847.82		0	168,880	0	0
North'n Mariana Is.	537		353,608	352,953		657.27		351,638		654.82		1,315	0	0	0
Puerto Rico	131,000		645,241,866	464,104,729		3,542.78		451,743,810		3,448.43		8,812,856	3,548,063	5,763,957	175,369,732

Appendix 2. Geographic Distribution of VA Expenditures for FFY96 (Summary of Expenditures by State).

State or Territory	Veteran Population	Rank	Total Expenditures	Total Non-Medical Non-Capital Expenditures	Rank	Per Capita	Rank **	Compensation and Pension	Rank	Per Capita	Rank	Readjustment Benefits and Vocational Rehabilitation	Insurance and Indemnities	Construction and Related Costs	Medical Services and Administrative Costs
Samoa (American)	817		2,987,900	2,984,311		3,652.77		2,932,453		3,589.29		0	51,858	0	0
Virgin Islands	4,822		3,325,630	3,324,983		689.54		3,120,150		647.07		922	203,911	0	0

* District of Columbia totals include Central Office funding (included in the Medical Services & Administrative Costs category).
** Ranked in order of Per Capita Total Non-Medical, Non-Capital Expenditures.

Appendix 3. VA Expenditures by Indiana County for FFY96.

County	Veteran Pop'n (*)	Total Non-Medical/ Non-Capital Expenditures	Per Capita Expenditures	Per Capita Rank	Compensation and Pension	Per Capita Expenditures	Per Capita Rank	Readjustment & Vocational Rehabilitation	Per Capita Expenditures	Per Capita Rank	Insurance and Indemnities	Per Capita Expenditures	Per Capita Rank
ADAMS	2,310	1,082,989	468.83	74	913,006	395.24	72	47,069	20.38	60	122,914	53.21	28
ALLEN	31,098	14,876,275	478.36	70	11,952,914	384.36	74	1,289,194	41.46	13	1,634,167	52.55	53
BARTHOLOMEW	7,380	3,693,371	500.45	65	3,116,384	422.27	67	193,213	26.18	35	383,774	52.00	76
BENTON	948	449,591	474.35	73	356,351	375.98	77	42,143	44.46	11	51,097	53.91	4
BLACKFORD	1,580	940,405	595.16	43	823,007	520.86	40	33,861	21.43	54	83,537	52.87	42
BOONE	4,193	1,811,553	432.09	82	1,507,358	359.54	83	85,744	20.45	59	218,451	52.11	73
BROWN	1,881	931,873	495.44	67	798,268	424.41	65	36,161	19.23	68	97,444	51.81	80
CARROLL	1,804	991,630	549.71	49	863,238	478.54	48	30,855	17.10	71	97,537	54.07	3
CASS	4,323	2,572,284	595.06	44	2,223,251	514.32	41	117,081	27.09	33	231,952	53.66	8
CLARK	11,195	7,836,952	700.02	21	6,662,847	595.14	21	596,818	53.31	8	577,287	51.56	85
CLAY	2,705	2,114,176	781.55	11	1,875,089	693.17	12	96,047	35.51	17	143,040	52.88	40
CLINTON	3,068	1,580,723	515.25	62	1,386,113	451.81	57	31,006	10.11	89	163,604	53.33	19
CRAWFORD	1,204	1,122,542	932.73	2	1,024,135	850.96	2	36,278	30.14	30	62,129	51.62	83
DAVIESS	2,795	2,287,213	818.38	6	2,062,326	737.92	5	78,909	28.23	32	145,978	52.23	69
DEARBORN	4,632	2,479,506	535.25	53	2,094,228	452.08	56	140,325	30.29	29	244,953	52.88	39
DECATUR	2,444	1,299,059	531.46	56	1,118,929	457.77	54	51,934	21.25	57	128,196	52.45	61
DE KALB	3,558	1,462,437	411.07	84	1,213,530	341.11	84	59,364	16.69	75	189,543	53.28	23
DELAWARE	12,096	7,430,420	614.28	38	5,899,311	487.70	47	892,006	73.74	3	639,103	52.84	44
DUBOIS	3,362	2,224,097	661.62	26	1,946,225	578.96	28	101,954	30.33	28	175,918	52.33	65
ELKHART	14,458	6,406,765	443.13	80	5,357,544	370.56	78	286,391	19.81	61	762,830	52.76	45
FAYETTE	2,900	1,803,524	621.88	36	1,610,304	555.26	32	41,429	14.29	82	151,791	52.34	64
FLOYD	7,251	5,081,664	700.83	20	4,295,631	592.43	22	407,603	56.21	7	378,430	52.19	71
FOUNTAIN	2,143	1,199,962	560.02	48	1,076,761	502.53	44	12,038	5.62	92	111,163	51.88	78
FRANKLIN	1,848	1,429,438	773.63	12	1,311,510	709.81	7	19,515	10.56	88	98,413	53.26	24
FULTON	2,294	1,185,765	516.92	60	1,045,286	455.68	55	18,065	7.88	90	122,414	53.37	17
GIBSON	3,596	2,358,227	655.86	29	2,085,477	580.01	27	81,738	22.73	48	191,012	53.12	30

County	Veteran Pop'n (*)	Total Non-Medical/ Non-Capital Expenditures	Per Capita Expenditures	Per Capita Rank	Compensation and Pension	Per Capita Expenditures	Per Capita Rank	Readjustment & Vocational Rehabilitation	Per Capita Expenditures	Per Capita Rank	Insurance and Indemnities	Per Capita Expenditures	Per Capita Rank
GRANT	9,097	6,998,178	769.27	13	6,318,037	694.50	11	202,642	22.28	50	477,499	52.49	58
GREENE	4,139	2,510,218	606.52	41	2,204,379	532.63	38	91,294	22.06	51	214,545	51.84	79
HAMILTON	12,428	4,908,339	394.93	86	4,000,763	321.91	88	287,193	23.11	45	620,383	49.92	92
HANCOCK	5,321	2,566,387	482.35	69	2,130,390	400.40	71	162,292	30.50	27	273,705	51.44	88
HARRISON	3,386	2,144,925	633.49	34	1,860,120	549.37	35	107,512	31.75	23	177,293	52.36	63
HENDRICKS	8,938	3,987,541	446.12	79	3,292,283	368.33	79	236,291	26.44	34	458,967	51.35	90
HENRY	5,620	3,295,740	586.42	45	2,865,708	509.90	43	134,794	23.98	39	295,238	52.53	55
HOWARD	9,597	5,068,645	528.16	57	4,258,547	443.75	60	299,565	31.22	25	510,533	53.20	29
HUNTINGTON	3,383	1,808,136	534.45	54	1,554,935	459.60	52	72,783	21.51	53	180,418	53.33	20
JACKSON	4,069	2,712,162	666.51	24	2,403,015	590.54	23	95,071	23.36	43	214,076	52.61	51
JASPER	2,442	942,319	385.82	89	770,731	315.56	89	43,361	17.75	70	128,227	52.50	57
JAY	2,141	1,112,013	519.34	59	962,339	449.44	59	36,135	16.88	72	113,539	53.03	34
JEFFERSON	3,604	1,973,830	547.72	50	1,701,732	472.22	49	86,180	23.91	40	185,918	51.59	84
JENNINGS	2,583	1,699,223	657.75	28	1,515,394	586.59	24	50,727	19.64	64	133,102	51.52	86
JOHNSON	9,711	4,950,572	509.77	63	4,101,550	422.34	66	351,959	36.24	15	497,063	51.18	91
KNOX	4,285	3,498,492	816.49	7	2,979,247	695.31	10	289,543	67.57	5	229,702	53.61	11
KOSCIUSKO	6,619	2,591,685	391.53	88	2,168,068	327.53	86	76,219	11.51	87	347,398	52.48	59
LA GRANGE	1,885	916,325	486.01	68	791,778	419.95	68	23,978	12.72	85	100,569	53.34	18
LAKE	49,262	22,102,722	448.68	78	18,025,697	365.92	81	1,423,917	28.91	31	2,653,108	53.86	6
LA PORTE	13,372	4,966,962	371.45	91	4,034,059	301.69	91	224,983	16.83	73	707,920	52.94	38
LAWRENCE	5,121	3,706,572	723.78	18	3,362,783	656.65	16	76,428	14.92	80	267,361	52.21	70
MADISON	14,729	7,442,461	505.31	64	6,322,224	429.25	63	341,562	23.19	44	778,675	52.87	41
MARION	83,115	56,320,505	677.62	23	46,233,958	556.26	31	5,681,922	68.36	4	4,404,625	52.99	37
MARSHALL	4,388	2,098,277	478.15	71	1,761,734	401.46	69	103,903	23.68	41	232,640	53.01	35
MARTIN	1,216	1,067,321	877.95	4	976,671	803.38	3	25,927	21.33	55	64,723	53.24	27
MIAMI	3,862	2,809,594	727.48	17	2,408,055	623.51	19	192,432	49.83	9	209,107	54.14	1

County	Veteran Pop'n (*)	Total Non-Medical/ Non-Capital Expenditures	Per Capita Expenditures	Per Capita Rank	Compensation and Pension	Per Capita Expenditures	Per Capita Rank	Readjustment & Vocational Rehabilitation	Per Capita Expenditures	Per Capita Rank	Insurance and Indemnities	Per Capita Expenditures	Per Capita Rank
MONROE	9,278	5,638,983	607.76	39	3,942,273	424.89	64	1,218,742	131.35	2	477,968	51.51	87
MONTGOMERY	3,777	1,432,288	379.17	90	1,146,964	303.64	90	86,874	23.00	47	198,450	52.54	54
MORGAN	6,333	3,266,046	515.73	61	2,796,892	441.64	61	138,289	21.84	52	330,865	52.25	68
NEWTON	1,395	731,328	524.29	58	629,475	451.27	58	27,129	19.45	66	74,724	53.57	12
NOBLE	3,688	1,630,082	442.04	81	1,356,631	367.89	80	76,501	20.75	58	196,950	53.41	16
OHIO	628	425,469	677.93	22	376,650	600.14	20	16,129	25.70	36	32,690	52.09	74
ORANGE	2,013	1,714,299	851.83	5	1,578,309	784.25	4	29,108	14.46	81	106,882	53.11	32
OWEN	2,099	1,601,407	762.97	14	1,441,385	686.73	14	51,046	24.32	38	108,976	51.92	77
PARKE	1,981	1,114,529	562.58	47	972,875	491.08	46	37,179	18.77	69	104,475	52.74	46
PERRY	2,307	1,496,619	648.79	30	1,346,722	583.81	25	28,858	12.51	86	121,039	52.47	60
PIKE	1,414	1,146,627	810.68	8	1,039,729	735.10	6	32,549	23.01	46	74,349	52.57	52
PORTER	14,705	5,206,391	354.05	92	3,988,874	271.25	92	452,437	30.77	26	765,080	52.03	75
POSEY	2,829	1,779,034	628.77	35	1,528,840	540.34	37	101,903	36.02	16	148,291	52.41	62
PULASKI	1,302	826,086	634.28	33	723,063	555.18	33	33,269	25.54	37	69,754	53.56	13
PUTNAM	3,635	1,737,378	477.96	72	1,425,834	392.25	73	121,907	33.54	21	189,637	52.17	72
RANDOLPH	2,806	1,101,974	392.76	87	906,350	323.04	87	45,146	16.09	76	150,478	53.63	10
RIPLEY	2,601	1,659,502	637.93	32	1,470,511	565.28	29	51,513	19.80	62	137,478	52.85	43
RUSH	1,790	895,309	500.26	66	769,393	429.90	62	29,910	16.71	74	96,006	53.64	9
ST. JOSEPH	26,107	12,125,878	464.48	75	9,844,361	377.08	76	889,865	34.09	18	1,391,652	53.31	21
SCOTT	2,062	1,472,894	714.44	19	1,320,116	640.34	18	46,302	22.46	49	106,476	51.65	82
SHELBY	4,283	2,294,365	535.64	52	2,006,165	468.36	51	64,404	15.04	79	223,796	52.25	67
SPENCER	2,185	1,249,227	571.65	46	1,091,731	499.58	45	42,270	19.34	67	115,226	52.73	47
STARKE	2,421	1,114,950	460.63	76	971,420	401.33	70	17,022	7.03	91	126,508	52.27	66
STEUBEN	3,190	1,456,177	456.45	77	1,224,327	383.78	75	67,840	21.27	56	164,010	51.41	89
SULLIVAN	2,180	1,707,024	782.97	10	1,517,105	695.86	9	74,099	33.99	20	115,820	53.12	31
SWITZERLAND	863	1,026,112	1,188.59	1	950,508	1,101.02	1	29,414	34.07	19	46,190	53.50	15
TIPPECANOE	11,487	10,100,417	879.26	3	7,895,105	687.28	13	1,600,430	139.32	1	604,882	52.66	50

County	Veteran Pop'n (*)	Total Non-Medical/ Non-Capital Expenditures	Per Capita Expenditures	Per Capita Rank	Compensation and Pension	Per Capita Expenditures	Per Capita Rank	Readjustment & Vocational Rehabilitation	Per Capita Expenditures	Per Capita Rank	Insurance and Indemnities	Per Capita Expenditures	Per Capita Rank
TIPTON	1,768	1,057,646	598.39	42	908,824	514.19	42	56,004	31.69	24	92,818	52.51	56
UNION	586	467,647	797.76	9	411,625	702.19	8	24,301	41.46	14	31,721	54.11	2
VANDERBURGH	18,199	13,526,813	743.27	16	11,666,959	641.07	17	890,667	48.94	10	969,187	53.25	25
VERMILLION	1,922	1,245,901	648.16	31	1,116,758	580.98	26	25,824	13.43	84	103,319	53.75	7
VIGO	11,874	7,884,528	664.00	25	6,558,647	552.34	34	693,622	58.41	6	632,259	53.25	26
WABASH	3,187	1,967,175	617.25	37	1,747,181	548.22	36	48,327	15.16	78	171,667	53.86	5
WARREN	916	487,798	532.41	55	421,029	459.54	53	17,953	19.60	65	48,816	53.28	22
WARRICK	4,627	2,808,730	607.04	40	2,415,950	522.15	39	149,108	32.23	22	243,672	52.66	49
WASHINGTON	2,567	1,953,779	761.05	15	1,757,176	684.47	15	60,532	23.58	42	136,071	53.00	36
WAYNE	8,142	5,383,400	661.19	27	4,599,607	564.92	30	351,453	43.17	12	432,340	53.10	33
WELLS	2,467	1,058,519	429.16	83	889,016	360.44	82	39,526	16.03	77	129,977	52.70	48
WHITE	2,561	1,391,275	543.21	51	1,203,696	469.97	50	50,445	19.70	63	137,134	53.54	14
WHITLEY	3,119	1,264,570	405.51	85	1,058,897	339.55	85	44,444	14.25	83	161,229	51.70	81
Total State	592,673	337,299,761	569.12		282,640,193	476.89		23,407,695	39.50		31,251,873	52.73	

(*) Veteran population data as of June 1995.

ENDNOTES

1. IDVA Organizational Chart, 1-1-98.

2. Meeting with Mr. William "Bill" Jackson, Director, IDVA, 3-11-98.

3. Telephone conversation with B. Keith Beesley, Counsel, State Personnel Department.

4. Ibid.

5. State of Indiana HRM Staffing Report, 2-27-98.

6. *Black's Law Dictionary*. St. Paul, MN: West Publishing Co., 1991, p.363.

7. Staffing reports from 1988-1998, Indiana State Archives, Commission on Public Records.

8. State Personnel Department 1998 Salary Schedule.

8. Staffing Report.

10. Survey conducted by Stephen Steed, IDVA Deputy Director .

11. IDVA *1998 Directory of Approved Programs*.

12. Veterans' Affairs Regional Office, Indianapolis, IN (number of veterans and other individuals receiving GI Bill benefits as of February, 1998); Stephen Steed, Deputy Director, IDVA (amount of GI Bill benefits received).

13.Telephone conversation with B. Keith Beesley, Counsel, State Personnel Department.

14. Renee Miller, Budget Analyst, State Budget Agency.

15. Ibid.

16. SAA Budgets, FY 1994-1998.

17. IDVA/SAA Reimbursement Contract with the federal government for FY 1998.

18. State Approving Agency Budgets - FY 1994 to FY 1998.

19. VA Form 21-22, August 1995.

20. IC 10-5-1-9 and 915 IAC 1-1-4.

21. IC 10-5-1-9 and 915 IAC 1-1-4.

22. 915 IAC 1-1-1.

23. IC 10-5-1-12.

24. 915 IAC 1-1-2.

25. Handout provided by the Indiana Department of Veterans' Affairs.

26. Conversation with Mr. William Jackson, Director, IDVA, March 11, 1998.

27. Conversation with Mr. William Jackson, Director, IDVA, March 11, 1998.

28. IDVA Conference (Training Sessions) Attendance Records.

29. Conversation with Mr. William Jackson, Director, IDVA, March 11, 1998.

30. *Sunset Performance Audit of Human Services Programs in Indiana*, Indiana Legislative Services Agency, December 1980, p. 180.

31. *Sunset Performance Audit of Human Services Programs in Indiana*, Indiana Legislative Services Agency, December 1980, p. 181.

32. *Sunset Performance Audit of Human Services Programs in Indiana*, Indiana Legislative Services Agency, December 1980, p. 181.

33. Final report of the Commission on Military and Veterans' Affairs, 1996, p. 4.